CITY OF NEWTON, MASSACHUSETTS

PURCHASING DEPARTMENT
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Fax (617) 796-1227

May 25, 2012

ADDENDUM #1

INVITATION FOR BID #12-77

STOP LOSS

THIS ADDENDUM IS TO: **Answer the following Questions:**

Q1. Can you please put employee census showing ages/DOBs & genders in an Excel spreadsheet?

A1. Attached is a census that answers both questions. I am unable to run a report for Harvard Pilgrim that has gender, so that is blank.

Q2. In order to proceed, we need the following:
Excel subscriber census for all employees covered under the stop loss indicating the subscriber's gender, date of birth, plan selection, singe/family coverage selection and active/retiree status.

A2. Attached is a census that answers both questions. I am unable to run a report for Harvard Pilgrim that has gender, so that is blank.

All other terms and conditions of this bid remain unchanged.

PLEASE ENSURE THAT YOU ACKNOWLEDGE THIS ADDENDUM ON YOUR BID FORM.

Thank you.

Paula J. Hudak
Assistant Purchasing Agent

TYPE	BIRTH DATE	GENDER	PLAN	PRODUCT
RET	11/23/1949	Male	P1IN	POS
RET	7/18/1944	Male	P1IN	POS
RET	3/10/1949	Male	P1IN	POS
RET	8/27/1949	Male	P1FA	POS
RET	6/25/1953	Male	P1FA	POS
RET	9/2/1947	Male	P1FA	POS
RET	7/29/1958	Male	P1FA	POS
RET	3/2/1947	Female	P1IN	POS
RET	6/29/1941	Female	P1IN	POS
RET	11/1/1948	Male	P1IN	POS
RET	2/20/1949	Female	P1FA	POS
RET	2/27/1948	Male	P1FA	POS
RET	10/10/1949	Male	P1FA	POS
RET	6/29/1947	Male	P1FA	POS
RET	1/22/1948	Female	P1IN	POS
RET	8/4/1950	Female	P1FA	POS
RET	5/19/1941	Male	P1IN	POS
RET	8/28/1925	Female	P1IN	POS
RET	9/14/1944	Male	P1IN	POS
RET	10/11/1934	Female	P1IN	POS
RET	2/16/1947	Male	P1IN	POS
RET	9/17/1953	Female	P1IN	POS
RET	5/20/1951	Female	P1IN	POS
RET	10/5/1926	Male	P1IN	POS
RET	6/25/1942	Male	P1IN	POS
RET	3/31/1956	Female	P1FA	POS
RET	4/29/1954	Female	P1FA	POS
RET	10/21/1948	Male	P1FA	POS
RET	10/7/1947	Male	P1IN	POS
RET	2/14/1950	Female	P1IN	POS
RET	7/15/1948	Female	P1IN	POS
RET	5/18/1946	Female	P1IN	POS
RET	4/18/1979	Female	P1IN	POS
RET	9/10/1949	Female	P1IN	POS
RET	9/13/1952	Female	P1IN	POS
RET	11/5/1948	Female	P1IN	POS
RET	11/12/1947	Female	P1IN	POS
RET	10/25/1947	Male	P1IN	OSA
RET	8/27/1947	Male	P1FA	OSA
RET	7/22/1945	Female	P1IN	OSA
RET	9/15/1941	Female	P1IN	OSA
RET	5/4/1948	Male	P1FA	OSA
RET	12/21/1955	Female	P1IN	OSA
RET	9/30/1950	Male	P1FA	OSA
RET	4/8/1956	Male	P1FA	OSA
RET	2/4/1949	Male	P1FA	OSA
RET	9/9/1977	Male	P1FA	OSA
RET	12/3/1948	Male	P1IN	OSA
RET	12/3/1922	Female	P1IN	OSA
RET	11/28/1956	Male	P1FA	OSA
RET	10/31/1952	Male	P1FA	OSA
RET	5/6/1959	Female	P1IN	OSA
RET	12/26/1953	Female	P1IN	OSA

RET	1/30/1949	Male	P1IN	OSA
RET	5/16/1950	Male	P1FA	OSA
RET	7/15/1949	Male	P1FA	OSA
RET	5/4/1952	Female	P1FA	OSA
RET	1/31/1927	Male	P1IN	OSA
RET	1/19/1944	Male	P1IN	OSA
RET	1/12/1941	Male	P1IN	OSA
RET	11/18/1940	Male	P1IN	OSA
RET	7/13/1940	Male	P1IN	OSA
RET	7/5/1952	Female	P1IN	OSA
RET	3/26/1945	Male	P1IN	OSA
RET	6/5/1948	Female	P1IN	OSA
RET	1/16/1943	Male	P1IN	OSA
RET	7/7/1951	Male	P1FA	OSA
RET	11/4/1952	Male	P1FA	OSA
RET	10/7/1947	Female	P1IN	OSA
RET	5/28/1946	Female	P1IN	OSA
RET	7/14/1964	Female	P1IN	OSA
RET	1/11/1950	Female	P1IN	OSA
RET	3/2/1954	Male	P1FA	OSA
RET	10/23/1959	Female	P1IN	OSA
RET	10/22/1951	Male	P1IN	OSA
ACT	6/27/1971	Male	P1FA	EPO
ACT	6/30/1968	Male	P1IN	EPO
ACT	5/22/1955	Female	P1IN	EPO
RET	11/5/1951	Male	P1IN	EPO
RET	8/23/1949	Male	P1FA	EPO
RET	5/18/1941	Male	P1IN	EPO
RET	12/1/1942	Male	P1FA	EPO
RET	3/29/1950	Male	P1FA	EPO
RET	3/8/1950	Male	P1IN	EPO
RET	9/8/1955	Male	P1FA	EPO
RET	3/21/1945	Male	P1IN	EPO
RET	5/3/1956	Male	P1IN	EPO
RET	9/13/1944	Male	P1IN	EPO
RET	4/27/1948	Male	P1FA	EPO
RET	7/16/1947	Female	P1IN	EPO
RET	11/13/1934	Female	P1IN	EPO
RET	10/27/1947	Male	P1FA	EPO
RET	8/30/1938	Male	P1IN	EPO
RET	9/3/1947	Female	P1IN	EPO
RET	9/15/1950	Male	P1FA	EPO
RET	12/12/1961	Male	P1IN	EPO
RET	4/11/1949	Male	P1FA	EPO
RET	10/26/1956	Male	P1FA	EPO
RET	1/3/1950	Female	P1FA	EPO
RET	4/5/1954	Female	P1IN	EPO
RET	9/15/1948	Male	P1FA	EPO
RET	2/10/1951	Male	P1FA	EPO
RET	3/1/1943	Male	P1FA	EPO
RET	9/3/1949	Male	P1IN	EPO
RET	9/21/1951	Male	P1FA	EPO
RET	5/30/1953	Male	P1FA	EPO
RET	1/4/1931	Male	P1IN	EPO
RET	2/24/1942	Male	P1IN	EPO
RET	3/28/1947	Male	P1IN	EPO

RET	7/8/1938	Male	P1IN	EPO
RET	6/14/1954	Male	P1FA	EPO
RET	2/1/1955	Male	P1FA	EPO
RET	7/11/1957	Male	P1FA	EPO
RET	2/11/1955	Female	P1IN	EPO
RET	4/21/1949	Male	P1IN	EPO
RET	2/22/1947	Male	P1FA	EPO
RET	3/23/1948	Male	P1IN	EPO
RET	9/30/1957	Female	P1IN	EPO
RET	8/2/1949	Male	P1IN	EPO
RET	11/11/1947	Male	P1FA	EPO
RET	1/24/1948	Male	P1IN	EPO
RET	12/24/1950	Female	P1IN	EPO
RET	6/13/1967	Male	P1FA	EPO
RET	10/22/1945	Male	P1FA	EPO
RET	12/20/1948	Female	P1IN	EPO
RET	12/5/1951	Male	P1IN	EPO
RET	10/21/1961	Male	P1FA	EPO
RET	11/10/1929	Male	P1IN	EPO
RET	2/13/1932	Male	P1IN	EPO
RET	6/12/1950	Female	P1IN	EPO
RET	4/9/1958	Female	P1IN	EPO
RET	2/27/1942	Female	P1IN	EPO
RET	4/30/1950	Male	P1IN	EPO
RET	8/21/1937	Female	P1IN	EPO
RET	11/24/1954	Male	P1FA	EPO
RET	2/18/1948	Female	P1FA	EPO
RET	9/16/1947	Male	P1IN	EPO
RET	5/13/1953	Male	P1FA	EPO
RET	8/22/1926	Male	P1IN	EPO
RET	10/29/1953	Female	P1IN	EPO
RET	8/30/1950	Female	P1IN	EPO
RET	9/20/1948	Male	P1FA	EPO
RET	10/30/1950	Male	P1IN	EPO
RET	1/3/1947	Male	P1FA	EPO
RET	5/30/1948	Male	P1FA	EPO
RET	7/21/1948	Male	P1IN	EPO
RET	1/29/1952	Female	P1IN	EPO
RET	10/16/1947	Male	P1FA	EPO
RET	8/17/1947	Male	P1IN	EPO
RET	11/16/1946	Male	P1FA	EPO
RET	9/9/1951	Male	P1FA	EPO
RET	9/14/1939	Male	P1IN	EPO
RET	8/1/1949	Male	P1FA	EPO
RET	5/20/1948	Male	P1FA	EPO
RET	10/22/1954	Male	P1IN	EPO
RET	9/20/1948	Male	P1IN	EPO
RET	5/6/1944	Male	P1IN	EPO
RET	2/6/1948	Male	P1FA	EPO
RET	8/20/1947	Male	P1FA	EPO
RET	9/27/1947	Female	P1IN	EPO
RET	4/1/1948	Male	P1FA	EPO
RET	5/21/1956	Male	P1FA	EPO
RET	7/24/1967	Male	P1FA	EPO
RET	12/14/1935	Male	P1IN	EPO
RET	10/7/1947	Male	P1IN	EPO

RET	3/31/1935	Female	P1IN	EPO
RET	6/19/1947	Female	P1FA	EPO
RET	7/10/1946	Male	P1FA	EPO
RET	9/18/1950	Male	P1FA	EPO
RET	5/5/1953	Female	P1FA	EPO
RET	2/27/1941	Male	P1FA	EPO
RET	6/9/1948	Female	P1IN	EPO
RET	7/22/1935	Female	P1IN	EPO
RET	1/3/1950	Female	P1FA	EPO
RET	11/2/1941	Female	P1IN	EPO
RET	11/19/1953	Male	P1FA	EPO
RET	1/28/1950	Female	P1IN	EPO
RET	11/9/1961	Male	P1FA	EPO
RET	5/12/1951	Male	P1IN	EPO
RET	7/23/1947	Male	P1IN	EPO
RET	9/11/1952	Female	P1IN	EPO
RET	12/4/1949	Male	P1FA	EPO
RET	1/8/1963	Male	P1FA	EPO
RET	8/14/1925	Female	P1IN	EPO
RET	2/14/1944	Male	P1IN	EPO
RET	2/19/1951	Male	P1FA	EPO
RET	1/27/1949	Male	P1IN	EPO
RET	5/13/1954	Male	P1FA	EPO
RET	2/22/1951	Female	P1IN	EPO
RET	11/18/1957	Female	P1IN	EPO
RET	12/9/1947	Female	P1IN	EPO
RET	8/4/1947	Male	P1FA	EPO
RET	8/14/1947	Male	P1FA	EPO
RET	12/25/1952	Female	P1IN	EPO
RET	4/3/1949	Male	P1IN	EPO
RET	1/30/1955	Male	P1IN	EPO
RET	6/6/1952	Male	P1FA	EPO
RET	2/17/1951	Female	P1FA	EPO
RET	12/14/1928	Male	P1IN	EPO
RET	6/30/1947	Female	P1IN	EPO
RET	6/21/1958	Male	P1FA	EPO
RET	11/10/1959	Male	P1IN	EPO
RET	1/1/1948	Female	P1IN	EPO
RET	5/16/1946	Male	P1IN	EPO
RET	3/4/1949	Male	P1FA	EPO
RET	1/31/1945	Female	P1IN	EPO
RET	3/9/1951	Female	P1FA	EPO
RET	9/6/1949	Male	P1FA	EPO
RET	3/30/1939	Male	P1IN	EPO
RET	11/1/1951	Male	P1FA	EPO
RET	2/27/1944	Female	P1IN	EPO
RET	3/7/1954	Male	P1FA	EPO
RET	9/29/1950	Female	P1IN	EPO
RET	8/27/1954	Male	P1FA	EPO
RET	4/7/1948	Female	P1IN	EPO
RET	5/28/1948	Male	P1IN	EPO
RET	7/2/1948	Male	P1FA	EPO
RET	2/4/1949	Male	P1FA	EPO
RET	5/27/1964	Male	P1FA	EPO
RET	10/15/1937	Male	P1IN	EPO
RET	9/8/1954	Male	P1IN	EPO

RET	8/31/1956	Male	P1FA	EPO
RET	10/10/1951	Male	P1IN	EPO
RET	4/18/1948	Male	P1IN	EPO
RET	8/10/1947	Male	P1FA	EPO
RET	9/8/1949	Male	P1FA	EPO
RET	2/3/1942	Male	P1IN	EPO
RET	4/13/1959	Male	P1IN	EPO
RET	2/5/1960	Female	P1FA	EPO
RET	10/28/1917	Male	P1IN	EPO
RET	7/10/1949	Male	P1FA	EPO
RET	3/29/1951	Female	P1IN	EPO
RET	11/19/1956	Female	P1IN	EPO
RET	8/8/1951	Female	P1FA	EPO
RET	2/25/1951	Male	P1IN	EPO
RET	10/18/1947	Male	P1FA	EPO
RET	4/5/1942	Male	P1IN	EPO
RET	2/6/1964	Female	P1FA	EPO
RET	5/12/1949	Male	P1FA	EPO
RET	12/18/1954	Female	P1IN	EPO
RET	12/18/1949	Male	P1FA	EPO
RET	10/15/1948	Female	P1IN	EPO
RET	11/29/1948	Male	P1IN	EPO
RET	11/7/1950	Male	P1FA	EPO
RET	2/27/1950	Female	P1IN	EPO
RET	9/8/1969	Male	P1FA	EPO
RET	4/28/1938	Male	P1IN	EPO
RET	6/16/1957	Male	P1FA	EPO
RET	8/1/1960	Female	P1IN	EPO
RET	1/8/1948	Male	P1FA	EPO
RET	8/9/1951	Female	P1IN	EPO
RET	3/25/1953	Female	P1IN	EPO
RET	2/17/1944	Male	P1IN	EPO
RET	4/28/1938	Male	P1IN	EPO
RET	1/30/1953	Male	P1FA	EPO
RET	8/8/1952	Male	P1FA	EPO
RET	4/16/1950	Male	P1FA	EPO
RET	9/7/1951	Female	P1IN	EPO
RET	12/24/1948	Male	P1FA	EPO
RET	10/20/1948	Female	P1IN	EPO
RET	10/18/1948	Male	P1IN	EPO
RET	6/6/1947	Female	P1IN	EPO
RET	6/25/1949	Female	P1IN	EPO
RET	10/5/1948	Female	P1IN	EPO
RET	5/27/1988	Female	P1IN	EPO
RET	3/18/1998	Female	P1IN	EPO
RET	5/24/1948	Female	P1IN	EPO
RET	10/21/1951	Female	P1FA	EPO
RET	12/21/1937	Female	P1IN	EPO
RET	8/13/1947	Female	P1IN	EPO
RET	4/23/1956	Female	P1IN	EPO
RET	5/25/1948	Female	P1IN	EPO
RET	10/14/1947	Male	P1IN	EPO
RET	1/5/1944	Female	P1IN	EPO
RET	1/3/1949	Female	P1IN	EPO
RET	9/25/1947	Female	P1IN	EPO
RET	9/27/1936	Female	P1IN	EPO

RET	12/23/1961	Female	P1FA	EPO
RET	10/2/1956	Female	P1IN	EPO
RET	11/4/1958	Female	P1FA	EPO
RET	10/14/1953	Female	P1IN	EPO
RET	11/23/1957	Female	P1IN	EPO
RET	4/14/1951	Male	P1IN	EPO
RET	11/3/1948	Female	P1IN	EPO
RET	12/29/1950	Female	P1IN	EPO
RET	3/24/1994	Male	P1IN	EPO
RET	3/7/1932	Male	P1IN	EPO
RET	5/15/1957	Female	P1IN	EPO
RET	7/10/1990	Male	P1IN	EPO
RET	10/28/1949	Female	P1IN	EPO
RET	9/4/2002	Female	P1IN	EPO
RET	6/19/1947	Female	P1IN	EPO
RET	8/2/1948	Female	P1IN	EPO
RET	2/22/1952	Female	P1IN	EPO
RET	8/19/1949	Female	P1IN	EPO
RET	11/1/1957	Female	P1IN	EPO
RET	3/14/1952	Female	P1IN	EPO
RET	5/8/1957	Female	P1IN	EPO
RET	9/13/1949	Male	P1FA	EPO
RET	4/22/1948	Male	P1IN	EPO
RET	1/18/1954	Female	P1IN	EPO
RET	3/15/1949	Female	P1IN	EPO
RET	4/29/1960	Male	P1FA	EPO
RET	6/6/1948	Female	P1IN	EPO
RET	7/30/1947	Female	P1IN	EPO
RET	5/23/1970	Female	P1FA	EPO
RET	2/28/1947	Female	P1IN	EPO
RET	9/25/1950	Female	P1FA	POS
RET	3/2/1950	Female	P1IN	POS
RET	2/1/1923	Female	P1IN	POS
RET	2/7/1950	Female	P1IN	POS
RET	12/23/1953	Female	P1FA	POS
RET	9/14/1931	Female	P1IN	POS
RET	1/16/1948	Female	P1FA	POS
RET	10/29/1935	Female	P1IN	POS
RET	11/19/1949	Male	P1FA	POS
RET	1/10/1946	Female	P1IN	POS
RET	9/18/1943	Female	P1IN	POS
RET	6/10/1944	Female	P1IN	POS
RET	10/4/1934	Female	P1FA	POS
RET	8/22/1933	Female	P1IN	POS
RET	5/3/1923	Female	P1IN	POS
RET	8/13/1926	Female	P1IN	POS
RET	8/8/1923	Female	P1IN	POS
RET	8/13/1951	Male	P1FA	POS
RET	9/4/1933	Female	P1IN	POS
RET	1/8/1927	Male	P1IN	POS
RET	3/22/1914	Female	P1IN	POS
RET	1/24/1935	Male	P1IN	POS
RET	1/13/1948	Female	P1IN	POS
RET	3/25/1947	Female	P1IN	POS
RET	7/26/1986	Male	P1IN	POS
RET	7/11/1953	Male	P1FA	POS

RET	2/21/1952	Female	P1IN	POS
RET	11/27/1929	Female	P1IN	POS
RET	1/28/1948	Female	P1IN	POS
RET	6/7/1921	Female	P1IN	POS
RET	4/2/1949	Male	P1IN	POS
RET	12/15/1956	Female	P1FA	POS
RET	1/17/1928	Female	P1IN	POS
RET	1/23/1939	Female	P1IN	POS
RET	10/6/1950	Female	P1IN	POS
RET	11/3/1950	Male	P1FA	POS
RET	8/20/1942	Female	P1IN	POS
RET	3/8/1950	Male	P1FA	POS
RET	8/22/1933	Female	P1IN	POS
RET	11/2/1939	Female	P1IN	POS
RET	2/7/1940	Male	P1IN	POS
RET	6/1/1937	Female	P1IN	POS
RET	1/27/1950	Male	P1FA	POS
RET	1/3/1949	Female	P1IN	POS
RET	11/11/1949	Female	P1IN	POS
RET	2/16/1937	Female	P1IN	POS
RET	5/28/1931	Female	P1IN	POS
RET	10/12/1956	Male	P1FA	POS
RET	4/6/1948	Male	P1IN	POS
RET	10/20/1947	Female	P1IN	POS
RET	12/20/1951	Female	P1FA	POS
RET	3/4/1947	Female	P1IN	POS
RET	5/6/1948	Female	P1IN	POS
RET	8/8/1949	Female	P1IN	POS
RET	4/25/1932	Female	P1IN	OSA
RET	12/23/1941	Male	P1IN	OSA
RET	2/16/1935	Male	P1IN	OSA
RET	9/9/1941	Female	P1IN	OSA
RET	2/19/1935	Male	P1IN	OSA
RET	10/31/1931	Female	P1IN	OSA
RET	10/24/1959	Female	P1IN	OSA
RET	9/8/1912	Female	P1IN	OSA
RET	1/3/1948	Male	P1FA	OSA
RET	7/2/1946	Female	P1IN	OSA
RET	2/8/1950	Female	P1IN	OSA
RET	3/5/1948	Female	P1IN	OSA
RET	2/5/1949	Female	P1IN	OSA
RET	4/20/1952	Male	P1FA	OSA
RET	7/3/1943	Female	P1IN	OSA
RET	5/29/1946	Female	P1IN	OSA
RET	5/12/1941	Female	P1IN	OSA
RET	8/26/1949	Female	P1FA	OSA
RET	1/14/1918	Female	P1IN	OSA
RET	3/15/1945	Female	P1IN	OSA
RET	9/8/1947	Female	P1IN	OSA
RET	6/7/1948	Female	P1IN	OSA
RET	3/15/1922	Female	P1IN	OSA
RET	1/20/1925	Female	P1IN	OSA
RET	3/31/1926	Female	P1IN	OSA
RET	3/6/1935	Male	P1IN	OSA
RET	11/6/1953	Female	P1FA	OSA
RET	8/11/1948	Female	P1IN	OSA

RET	8/18/1915	Female	P1IN	OSA
RET	8/1/1938	Female	P1IN	OSA
RET	6/26/1947	Male	P1IN	OSA
RET	1/8/1950	Female	P1FA	OSA
RET	10/2/1921	Female	P1IN	OSA
RET	7/24/1949	Female	P1FA	OSA
RET	3/24/1949	Female	P1IN	OSA
RET	6/11/1934	Male	P1IN	EPO
RET	5/8/1935	Female	P1IN	EPO
RET	8/12/1952	Female	P1IN	EPO
RET	7/1/1947	Female	P1IN	EPO
RET	10/4/1950	Female	P1FA	EPO
RET	11/4/1920	Female	P1IN	EPO
RET	6/24/1947	Female	P1IN	EPO
RET	11/22/1950	Male	P1FA	EPO
RET	7/14/1950	Female	P1IN	EPO
RET	9/12/1948	Female	P1IN	EPO
RET	9/15/1946	Male	P1IN	EPO
RET	11/10/1948	Female	P1IN	EPO
RET	10/22/1953	Male	P1FA	EPO
RET	3/18/1937	Male	P1IN	EPO
RET	8/28/1948	Female	P1IN	EPO
RET	9/23/1939	Female	P1IN	EPO
RET	9/19/1937	Male	P1FA	EPO
RET	1/25/1942	Female	P1IN	EPO
RET	12/20/1950	Female	P1FA	EPO
RET	2/5/1932	Female	P1IN	EPO
RET	8/15/1953	Female	P1FA	EPO
RET	1/2/1951	Male	P1FA	EPO
RET	5/14/1948	Female	P1IN	EPO
RET	7/23/1928	Female	P1IN	EPO
RET	12/16/1950	Female	P1FA	EPO
RET	10/18/1948	Female	P1IN	EPO
RET	3/13/1951	Female	P1IN	EPO
RET	11/15/1950	Female	P1FA	EPO
RET	12/10/1947	Male	P1FA	EPO
RET	4/21/1951	Male	P1FA	EPO
RET	12/27/1952	Female	P1FA	EPO
RET	9/20/1950	Female	P1FA	EPO
RET	5/2/1943	Female	P1IN	EPO
RET	3/6/1942	Female	P1IN	EPO
RET	6/13/1948	Female	P1IN	EPO
RET	9/9/1938	Female	P1IN	EPO
RET	2/17/1959	Female	P1FA	EPO
RET	7/24/1950	Male	P1FA	EPO
RET	4/20/1948	Female	P1IN	EPO
RET	1/30/1948	Female	P1FA	EPO
RET	11/30/1928	Female	P1IN	EPO
RET	10/12/1950	Male	P1FA	EPO
RET	11/16/1951	Male	P1FA	EPO
RET	6/7/1949	Male	P1FA	EPO
RET	11/5/1951	Female	P1IN	EPO
RET	9/11/1948	Male	P1FA	EPO
RET	12/1/1948	Female	P1IN	EPO
RET	11/7/1946	Male	P1IN	EPO
RET	1/28/1948	Female	P1IN	EPO

RET	6/9/1932	Female	P1IN	EPO
RET	4/18/1942	Female	P1IN	EPO
RET	4/7/1951	Female	P1IN	EPO
RET	7/14/1948	Female	P1FA	EPO
RET	9/21/1951	Female	P1IN	EPO
RET	12/29/1943	Male	P1FA	EPO
RET	1/8/1951	Male	P1FA	EPO
RET	7/21/1953	Male	P1FA	EPO
RET	6/30/1937	Female	P1IN	EPO
RET	10/3/1955	Female	P1FA	EPO
RET	8/25/1948	Female	P1IN	EPO
RET	8/24/1953	Female	P1FA	EPO
RET	4/20/1929	Male	P1IN	EPO
RET	5/3/1948	Female	P1FA	EPO
RET	7/10/1925	Male	P1FA	EPO
RET	8/25/1950	Female	P1IN	EPO
RET	7/3/1951	Male	P1IN	EPO
RET	2/3/1951	Female	P1IN	EPO
RET	8/6/1952	Female	P1FA	EPO
RET	3/13/1948	Female	P1IN	EPO
RET	7/3/1952	Female	P1IN	EPO
RET	4/8/1951	Female	P1IN	EPO
RET	7/12/1947	Female	P1IN	EPO
RET	11/7/1947	Female	P1IN	EPO
RET	9/26/1949	Male	P1IN	EPO
RET	7/22/1923	Female	P1IN	EPO
RET	7/7/1951	Female	P1IN	EPO
RET	10/11/1948	Female	P1IN	EPO
RET	4/19/1948	Female	P1FA	EPO
RET	2/26/1948	Female	P1FA	EPO
ACT	4/10/1958	Male	P1IN	EPO
ACT	11/14/1982	Male	P1IN	EPO
ACT	5/26/1962	Male	P1FA	EPO
ACT	3/13/1971	Male	P1IN	EPO
ACT	6/28/1975	Male	P1FA	EPO
ACT	7/23/1949	Male	P1FA	EPO
ACT	3/13/1955	Male	P1FA	EPO
ACT	7/13/1973	Male	P1FA	EPO
ACT	1/15/1970	Male	P1FA	EPO
ACT	2/26/1958	Male	P1FA	EPO
ACT	9/15/1958	Male	P1FA	EPO
ACT	12/27/1970	Male	P1FA	EPO
ACT	12/11/1973	Male	P1IN	EPO
ACT	3/30/1961	Male	P1FA	EPO
ACT	1/27/1981	Male	P1IN	EPO
ACT	4/15/1959	Male	P1FA	EPO
ACT	4/3/1959	Male	P1FA	EPO
ACT	3/18/1981	Male	P1IN	EPO
ACT	12/29/1978	Male	P1IN	EPO
ACT	2/1/1962	Male	P1IN	EPO
ACT	3/9/1958	Male	P1FA	EPO
ACT	9/27/1947	Male	P1FA	EPO
ACT	8/6/1973	Male	P1FA	EPO
ACT	10/6/1960	Male	P1FA	EPO
ACT	7/13/1964	Male	P1IN	EPO
ACT	7/29/1976	Male	P1FA	EPO

ACT	5/19/1974	Male	P1FA	EPO
ACT	10/3/1977	Male	P1FA	EPO
ACT	8/15/1979	Male	P1FA	EPO
ACT	2/26/1957	Male	P1FA	EPO
ACT	5/15/1968	Female	P1IN	EPO
ACT	12/20/1974	Male	P1FA	EPO
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ACT	2/16/1971	Male	P1FA	EPO
ACT	1/18/1967	Male	P1FA	EPO
ACT	9/10/1954	Male	P1FA	EPO
ACT	4/15/1972	Male	P1FA	EPO
ACT	7/18/1972	Male	P1FA	EPO
ACT	1/2/1976	Male	P1FA	EPO
ACT	10/12/1977	Male	P1IN	EPO
ACT	4/14/1968	Male	P1FA	EPO
ACT	2/14/1952	Male	P1IN	EPO
ACT	3/1/1969	Male	P1FA	EPO
ACT	12/10/1958	Male	P1IN	EPO
ACT	3/8/1953	Male	P1FA	EPO
ACT	11/27/1962	Male	P1FA	EPO
ACT	10/7/1971	Male	P1FA	EPO
ACT	4/21/1958	Male	P1IN	EPO
ACT	5/25/1981	Male	P1IN	EPO
ACT	8/7/1963	Male	P1FA	EPO
ACT	1/11/1960	Male	P1FA	EPO
ACT	12/22/1967	Male	P1FA	EPO
ACT	6/11/1980	Male	P1FA	EPO
ACT	8/15/1975	Male	P1IN	EPO
ACT	4/8/1977	Male	P1FA	EPO
ACT	10/2/1977	Male	P1IN	EPO
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ACT	11/3/1963	Male	P1FA	EPO
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ACT	12/29/1955	Male	P1IN	EPO
ACT	4/15/1969	Male	P1IN	EPO
ACT	5/4/1963	Male	P1FA	EPO
ACT	1/30/1964	Male	P1FA	EPO
ACT	10/12/1958	Male	P1FA	EPO
ACT	4/17/1970	Male	P1FA	EPO
ACT	9/22/1956	Male	P1FA	EPO
ACT	2/28/1960	Male	P1FA	EPO
ACT	6/11/1986	Male	P1IN	EPO

ACT	12/15/1989	Male	P1IN	EPO
ACT	7/31/1985	Male	P1FA	EPO
ACT	4/30/1984	Male	P1FA	EPO
ACT	4/8/1975	Male	P1FA	EPO
ACT	8/27/1990	Male	P1IN	EPO
ACT	8/14/1983	Male	P1IN	EPO
ACT	8/15/1983	Male	P1IN	EPO
ACT	9/17/1980	Male	P1IN	EPO
ACT	12/13/1983	Male	P1IN	EPO
ACT	10/18/1981	Male	P1IN	EPO
ACT	4/16/1981	Male	P1FA	EPO
ACT	3/2/1981	Male	P1FA	EPO
ACT	5/13/1985	Male	P1IN	EPO
ACT	8/6/1985	Male	P1IN	EPO
ACT	11/29/1984	Male	P1IN	EPO
ACT	3/26/1981	Male	P1IN	EPO
ACT	10/26/1986	Male	P1IN	EPO
ACT	9/21/1982	Male	P1IN	EPO
ACT	7/3/1976	Male	P1FA	EPO
ACT	11/14/1973	Female	P1IN	EPO
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ACT	3/29/1978	Male	P1FA	EPO
ACT	8/7/1985	Male	P1IN	EPO
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ACT	9/2/1966	Male	P1FA	EPO
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ACT	11/3/1951	Male	P1FA	EPO
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ACT	3/23/1971	Male	P1FA	EPO
ACT	9/11/1957	Male	P1FA	EPO
ACT	10/9/1985	Male	P1IN	EPO
ACT	6/25/1957	Male	P1FA	EPO

ACT	4/21/1958	Female	P1IN	EPO
ACT	1/18/1964	Male	P1FA	EPO
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ACT	12/25/1954	Male	P1FA	EPO
ACT	4/11/1961	Male	P1FA	EPO
ACT	7/15/1959	Male	P1FA	EPO
ACT	9/9/1944	Male	P1FA	EPO
ACT	11/14/1950	Male	P1IN	EPO
ACT	7/30/1965	Male	P1IN	EPO
ACT	2/7/1954	Male	P1FA	EPO
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ACT	1/30/1975	Female	P1FA	EPO
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ACT	2/24/1982	Male	P1FA	EPO
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ACT	9/24/1946	Male	P1FA	EPO
ACT	1/6/1959	Male	P1IN	EPO
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ACT	8/10/1957	Male	P1IN	EPO
ACT	6/16/1966	Male	P1FA	EPO
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ACT	5/3/1969	Male	P1FA	EPO
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ACT	11/30/1975	Male	P1FA	EPO
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ACT	12/19/1976	Male	P1FA	EPO
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ACT	7/5/1951	Female	P1IN	EPO
ACT	5/4/1967	Female	P1IN	EPO
ACT	7/14/1950	Male	P1FA	EPO

ACT	3/11/1954	Female	P1FA	EPO
ACT	1/28/1950	Female	P1FA	EPO
ACT	11/25/1962	Female	P1FA	EPO
ACT	8/31/1939	Female	P1IN	EPO
ACT	4/14/1962	Female	P1FA	EPO
ACT	9/13/1957	Female	P1FA	EPO
ACT	3/24/1965	Female	P1FA	EPO
ACT	4/25/1966	Female	P1IN	EPO
ACT	1/26/1951	Male	P1FA	EPO
ACT	10/5/1950	Female	P1FA	EPO
ACT	3/23/1968	Female	P1FA	EPO
ACT	9/6/1954	Male	P1FA	EPO
ACT	2/18/1966	Female	P1IN	EPO
ACT	11/27/1953	Female	P1FA	EPO
ACT	12/15/1950	Male	P1FA	EPO
ACT	8/23/1949	Female	P1FA	EPO
ACT	4/3/1958	Female	P1FA	EPO
ACT	11/18/1955	Female	P1FA	EPO
ACT	6/4/1961	Male	P1FA	EPO
ACT	2/4/1959	Female	P1IN	EPO
ACT	5/31/1952	Female	P1IN	EPO
ACT	4/15/1961	Female	P1IN	EPO
ACT	7/27/1949	Male	P1IN	EPO
ACT	4/1/1971	Female	P1FA	EPO
ACT	12/28/1970	Male	P1IN	EPO
ACT	3/26/1959	Female	P1FA	EPO
ACT	6/13/1953	Male	P1IN	EPO
ACT	6/30/1954	Female	P1FA	EPO
ACT	2/17/1954	Female	P1IN	EPO
ACT	10/28/1941	Female	P1FA	EPO
ACT	10/27/1950	Female	P1IN	EPO
ACT	5/19/1958	Female	P1IN	EPO
ACT	10/21/1961	Female	P1IN	EPO
ACT	10/18/1963	Female	P1FA	EPO
ACT	6/15/1960	Male	P1FA	EPO
ACT	2/27/1965	Male	P1FA	EPO
ACT	5/23/1952	Female	P1FA	EPO
ACT	5/7/1959	Male	P1IN	EPO
ACT	7/30/1969	Female	P1IN	EPO
ACT	8/8/1959	Female	P1FA	EPO
ACT	8/17/1978	Female	P1IN	EPO
ACT	9/18/1939	Female	P1FA	EPO
ACT	4/14/1967	Female	P1IN	EPO
ACT	1/24/1951	Female	P1IN	EPO
ACT	6/18/1964	Female	P1FA	EPO
ACT	2/13/1979	Female	P1IN	EPO
ACT	6/21/1949	Female	P1IN	EPO
ACT	10/19/1962	Male	P1IN	EPO
ACT	7/25/1951	Female	P1IN	EPO
ACT	6/6/1965	Female	P1FA	EPO
ACT	11/4/1960	Female	P1IN	EPO
ACT	7/9/1948	Female	P1IN	EPO
ACT	5/10/1958	Female	P1IN	EPO
ACT	10/2/1951	Female	P1IN	EPO
ACT	11/6/1959	Female	P1IN	EPO
ACT	3/31/1978	Male	P1IN	EPO

ACT	2/12/1958	Male	P1FA	EPO
ACT	4/1/1946	Female	P1FA	EPO
ACT	3/11/1973	Male	P1FA	EPO
ACT	1/3/1943	Female	P1IN	EPO
ACT	7/12/1959	Male	P1FA	EPO
ACT	4/27/1949	Male	P1IN	EPO
ACT	1/11/1988	Male	P1IN	EPO
ACT	5/27/1989	Female	P1IN	EPO
ACT	2/9/1982	Female	P1FA	EPO
ACT	9/14/1984	Male	P1IN	EPO
ACT	6/24/1985	Female	P1IN	EPO
ACT	4/22/1985	Female	P1FA	EPO
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ACT	5/3/1986	Female	P1IN	EPO
ACT	12/20/1973	Female	P1FA	EPO
ACT	12/29/1982	Male	P1IN	EPO
ACT	2/5/1986	Female	P1IN	EPO
ACT	2/28/1984	Male	P1IN	EPO
ACT	10/4/1967	Female	P1IN	EPO
ACT	2/17/1984	Male	P1IN	EPO
ACT	8/2/1985	Female	P1IN	EPO
ACT	2/14/1982	Female	P1IN	EPO
ACT	11/2/1958	Female	P1FA	EPO
ACT	8/4/1978	Male	P1IN	EPO
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ACT	6/19/1963	Female	P1FA	EPO
ACT	7/17/1981	Female	P1IN	EPO
ACT	2/15/1949	Male	P1IN	EPO
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ACT	3/4/1956	Female	P1IN	EPO
ACT	11/29/1985	Female	P1IN	EPO
ACT	5/1/1963	Female	P1FA	EPO
ACT	7/6/1976	Female	P1IN	EPO
ACT	12/7/1983	Female	P1IN	EPO
ACT	1/19/1940	Female	P1IN	EPO
ACT	2/2/1954	Male	P1IN	EPO
ACT	10/12/1984	Male	P1IN	EPO
ACT	5/17/1985	Male	P1IN	EPO
ACT	1/31/1952	Female	P1FA	EPO
ACT	12/17/1968	Female	P1FA	EPO
ACT	9/16/1968	Male	P1FA	OSA
ACT	3/6/1975	Female	P1IN	EPO
ACT	12/27/1965	Male	P1IN	EPO
ACT	7/8/1942	Female	P1IN	EPO
ACT	9/4/1961	Female	P1FA	EPO
ACT	12/17/1951	Female	P1IN	EPO
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ACT	8/9/1974	Female	P1FA	EPO
ACT	11/26/1978	Female	P1FA	EPO
ACT	2/15/1947	Male	P1IN	EPO
ACT	6/28/1982	Female	P1IN	EPO
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ACT	7/15/1949	Female	P1IN	EPO

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ACT	5/29/1955	Female	P1FA	EPO
ACT	8/1/1951	Female	P1IN	EPO
ACT	8/11/1972	Female	P1IN	EPO
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ACT	9/6/1955	Male	P1IN	EPO
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ACT	11/16/1975	Female	P1FA	EPO
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ACT	5/25/1960	Female	P1IN	EPO
ACT	7/23/1967	Female	P1FA	EPO
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ACT	3/15/1972	Female	P1IN	EPO
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ACT	12/10/1969	Female	P1IN	EPO
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ACT	11/5/1954	Female	P1FA	EPO
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ACT	4/27/1952	Female	P1FA	EPO
ACT	11/4/1948	Female	P1IN	EPO
ACT	1/27/1961	Female	P1FA	EPO
ACT	11/4/1969	Female	P1FA	EPO
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ACT	6/28/1960	Female	P1IN	EPO
ACT	5/6/1982	Female	P1IN	EPO
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ACT	1/25/1975	Male	P1IN	EPO
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ACT	9/1/1975	Male	P1IN	EPO
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ACT	3/28/1979	Female	P1IN	EPO
ACT	7/10/1956	Female	P1FA	EPO
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ACT	10/15/1974	Male	P1FA	EPO
ACT	5/16/1963	Female	P1FA	EPO
ACT	10/22/1959	Female	P1FA	EPO
ACT	2/6/1950	Female	P1FA	EPO
ACT	10/22/1974	Female	P1FA	EPO
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ACT	10/2/1956	Female	P1FA	EPO
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ACT	9/7/1975	Female	P1FA	EPO
ACT	5/7/1974	Female	P1IN	EPO
ACT	7/14/1941	Female	P1IN	EPO
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ACT	1/22/1954	Male	P1FA	EPO
ACT	3/6/1959	Male	P1IN	EPO
ACT	11/21/1944	Male	P1FA	EPO
ACT	4/3/1950	Female	P1IN	EPO
ACT	6/10/1957	Female	P1FA	EPO
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ACT	11/12/1969	Male	P1FA	EPO
ACT	10/2/1956	Male	P1FA	EPO
ACT	4/2/1983	Female	P1IN	EPO
ACT	3/21/1963	Female	P1IN	EPO
ACT	9/24/1963	Male	P1FA	EPO
ACT	11/8/1974	Female	P1FA	EPO
ACT	2/3/1961	Female	P1FA	EPO

ACT	1/13/1975	Female	P1FA	EPO
ACT	8/6/1980	Male	P1IN	EPO
ACT	11/23/1977	Female	P1FA	EPO
ACT	7/30/1946	Female	P1FA	EPO
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ACT	5/4/1961	Male	P1IN	EPO
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ACT	9/1/1966	Female	P1FA	EPO
ACT	1/28/1958	Female	P1FA	EPO
ACT	8/17/1977	Male	P1IN	EPO
ACT	9/6/1947	Female	P1FA	EPO
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ACT	6/21/1951	Male	P1IN	EPO
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ACT	8/1/1949	Female	P1FA	EPO
ACT	9/19/1971	Female	P1FA	EPO
ACT	6/16/1941	Female	P1IN	EPO
ACT	8/17/1959	Female	P1IN	EPO
ACT	10/11/1956	Female	P1FA	EPO
ACT	3/3/1949	Female	P1FA	EPO
ACT	11/20/1977	Female	P1IN	EPO
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ACT	12/10/1971	Female	P1FA	EPO
ACT	2/27/1949	Female	P1IN	EPO
ACT	11/22/1971	Female	P1FA	EPO
ACT	3/3/1952	Female	P1FA	EPO
ACT	11/21/1974	Male	P1FA	EPO
ACT	3/22/1967	Male	P1IN	EPO
ACT	5/7/1966	Female	P1IN	EPO
ACT	1/9/1972	Female	P1FA	EPO
ACT	6/30/1976	Female	P1IN	EPO
ACT	9/25/1967	Female	P1IN	EPO
ACT	10/15/1974	Female	P1FA	EPO
ACT	2/18/1960	Female	P1FA	EPO
ACT	7/9/1975	Female	P1FA	EPO
ACT	6/1/1961	Female	P1FA	EPO
ACT	3/25/1945	Female	P1FA	EPO
ACT	4/27/1950	Female	P1FA	EPO
ACT	8/9/1965	Female	P1IN	EPO
ACT	6/18/1955	Male	P1FA	EPO
ACT	9/26/1967	Female	P1FA	EPO
ACT	12/7/1968	Female	P1FA	EPO
ACT	1/6/1967	Female	P1FA	EPO
ACT	5/31/1968	Female	P1FA	EPO
ACT	9/12/1968	Female	P1FA	EPO
ACT	11/13/1979	Male	P1IN	EPO
ACT	6/16/1963	Male	P1FA	EPO
ACT	9/22/1973	Female	P1FA	EPO
ACT	3/31/1966	Female	P1FA	EPO
ACT	3/11/1976	Female	P1FA	EPO
ACT	4/25/1966	Female	P1IN	EPO
ACT	9/19/1969	Female	P1IN	EPO
ACT	7/11/1949	Male	P1FA	EPO
ACT	10/8/1956	Female	P1FA	EPO
ACT	5/14/1959	Female	P1FA	EPO
ACT	6/25/1971	Female	P1FA	EPO
ACT	3/25/1947	Female	P1FA	EPO
ACT	7/8/1956	Female	P1FA	EPO
ACT	8/22/1962	Female	P1IN	EPO
ACT	2/13/1971	Female	P1FA	EPO
ACT	5/7/1980	Female	P1FA	EPO
ACT	10/25/1947	Female	P1IN	EPO
ACT	7/14/1952	Male	P1IN	EPO
ACT	9/30/1969	Male	P1FA	EPO
ACT	6/7/1950	Female	P1FA	EPO
ACT	5/22/1976	Male	P1FA	EPO
ACT	5/7/1961	Male	P1IN	EPO
ACT	10/1/1976	Male	P1IN	EPO
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ACT	8/16/1958	Female	P1FA	EPO
ACT	3/11/1961	Male	P1FA	EPO
ACT	6/9/1953	Male	P1FA	EPO
ACT	2/25/1951	Male	P1FA	EPO
ACT	3/10/1973	Female	P1IN	EPO
ACT	5/26/1954	Male	P1FA	EPO
ACT	9/17/1952	Female	P1FA	EPO

ACT	5/8/1970	Male	P1FA	EPO
ACT	10/1/1971	Female	P1IN	EPO
ACT	12/14/1975	Male	P1FA	EPO
ACT	6/19/1969	Male	P1FA	EPO
ACT	11/28/1976	Female	P1IN	EPO
ACT	1/20/1963	Female	P1FA	EPO
ACT	9/18/1966	Male	P1FA	EPO
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ACT	5/2/1949	Female	P1FA	EPO
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ACT	2/12/1969	Male	P1FA	EPO
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ACT	11/3/1949	Female	P1FA	EPO
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ACT	2/11/1972	Female	P1IN	EPO
ACT	4/23/1970	Male	P1IN	EPO
ACT	2/13/1974	Female	P1FA	EPO
ACT	11/23/1961	Male	P1IN	EPO
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ACT	5/14/1972	Female	P1FA	EPO
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ACT	5/6/1974	Female	P1FA	EPO
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ACT	12/18/1987	Female	P1IN	EPO
ACT	5/31/1959	Female	P1IN	EPO
ACT	11/24/1966	Male	P1FA	OSA
ACT	7/16/1955	Female	P1FA	OSA
ACT	4/7/1986	Female	P1IN	PPO
ACT	8/27/1984	Male	P1IN	PPO
ACT	3/4/1957	Male	P1FA	PPO
ACT	7/20/1964	Male	P1FA	PPO
ACT	7/28/1949	Male	P1FA	PPO
ACT	3/23/1957	Male	P1FA	PPO
ACT	10/9/1957	Male	P1IN	PPO
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ACT	12/28/1959	Male	P1IN	PPO
ACT	5/24/1957	Male	P1IN	PPO
ACT	2/4/1947	Female	P1FA	PPO
ACT	5/23/1955	Female	P1FA	PPO
ACT	6/26/1948	Female	P1FA	PPO
ACT	5/21/1969	Female	P1FA	PPO
ACT	3/16/1959	Male	P1FA	PPO
ACT	11/16/1967	Female	P1FA	PPO
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ACT	9/19/1968	Female	P1FA	PPO
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ACT	1/7/1973	Female	P1FA	PPO
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ACT	12/9/1954	Female	P1FA	PPO

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ACT	12/2/1971	Female	P1FA	PPO
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ACT	11/1/1956	Female	P1FA	PPO
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RET	9/1/1973	Family	HMO
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ACT	11/4/1972	Individual	HMO
ACT	7/14/1956	Family	HMO
RET	4/27/1949	Family	HMO
ACT	11/15/1969	Family	HMO
ACT	6/10/1963	Family	HMO
ACT	6/10/1949	Family	HMO
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RET	11/10/1947	Individual	HMO
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RET	6/24/1951	Individual	HMO
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ACT	1/20/1974	Family	HMO
ACT	3/19/1972	Individual	HMO
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ACT	6/17/1981	Individual	HMO

ACT	8/25/1962	Individual	HMO
ACT	4/25/1945	Family	HMO
ACT	7/22/1964	Family	HMO
ACT	7/13/1980	Individual	HMO
ACT	12/3/1947	Individual	HMO
ACT	8/1/1980	Individual	HMO
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RET	11/3/1947	Individual	HMO
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ACT	10/5/1976	Family	HMO
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RET	10/12/1949	Individual	HMO

RET	10/6/1947	Individual	HMO
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ACT	4/16/1966	Family	HMO
ACT	10/20/1957	Family	HMO
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ACT	2/6/1966	Family	HMO

ACT	9/12/1967	Family	HMO
RET	5/8/1954	Family	HMO
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RET	7/30/1947	Family	HMO
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RET	11/25/1945	Individual	HMO
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RET	8/13/1950	Family	HMO
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ACT	8/8/1983	Individual	HMO
ACT	11/8/1948	Family	HMO
RET	12/5/1943	Individual	HMO
ACT	3/2/1972	Individual	HMO
ACT	5/1/1973	Family	HMO
ACT	8/30/1977	Family	HMO
ACT	10/9/1984	Individual	HMO
ACT	7/25/1984	Individual	HMO
ACT	9/23/1952	Family	HMO
ACT	12/18/1951	Family	HMO
ACT	9/22/1958	Family	HMO
ACT	2/19/1977	Individual	HMO
RET	7/18/1947	Family	HMO
ACT	12/16/1955	Family	HMO
ACT	6/28/1961	Family	HMO
ACT	9/30/1959	Family	HMO
ACT	4/4/1979	Family	HMO
ACT	3/8/1960	Family	HMO
RET	1/17/1951	Family	HMO
ACT	2/25/1981	Family	HMO
RET	7/7/1949	Individual	HMO
ACT	6/5/1970	Family	HMO
ACT	8/12/1977	Individual	HMO
ACT	3/31/1977	Individual	HMO
ACT	6/10/1967	Family	HMO
RET	9/4/1941	Individual	HMO
ACT	7/31/1978	Individual	HMO
ACT	2/14/1943	Individual	HMO
RET	7/29/1955	Family	HMO
ACT	7/14/1966	Family	HMO
ACT	12/4/1983	Individual	HMO
ACT	6/13/1985	Individual	HMO
ACT	10/27/1985	Individual	HMO
ACT	6/17/1975	Individual	HMO
ACT	5/1/1951	Family	HMO
ACT	11/30/1981	Individual	HMO
ACT	11/9/1984	Individual	HMO
ACT	5/30/1974	Family	HMO
ACT	2/12/1982	Family	HMO
ACT	7/14/1977	Family	HMO
ACT	3/22/1957	Family	HMO
ACT	4/6/1957	Individual	HMO
ACT	6/9/1963	Family	HMO
RET	7/3/1948	Family	HMO
ACT	5/22/1950	Individual	HMO

ACT	11/25/1966	Family	HMO
ACT	5/13/1954	Family	HMO
ACT	7/20/1971	Family	HMO
ACT	11/10/1982	Individual	HMO
RET	9/17/1947	Individual	HMO
ACT	5/28/1985	Individual	HMO
ACT	2/2/1980	Family	HMO

CITY OF NEWTON
PURCHASING DEPARTMENT

CONTRACT FOR HUMAN RESOURCES

REQUEST FOR PROPOSAL:

STOP LOSS REINSURANCE

RFP #12-77

Proposal Due Date: June 1, 2012 at 10:30 a.m.

MAY 2012

Setti D. Warren, Mayor

GROUP MEDICAL REINSURANCE (STOP LOSS)

REQUEST FOR PROPOSAL

FOR COVERAGE PERIOD JULY 1, 2012 THRU JUNE 30, 2013

PROPOSAL Submission Instructions

The City of Newton is not required by law to seek competitive quotes for Insurance Coverage. When it does decide to seek competitive quotes for insurance, it is not required to follow any specified procedure or laws.

The City of Newton will be the sole judge of whether or not a proposal meets the criteria of the Request for Proposal, and its decision shall be final.

The City of Newton will be the sole judge of whether or not a particular proposal has the highest value for the City of Newton compared to other proposals based on the selection criteria, and its decision shall be final.

RFP DATES:

Release Date:	May 17, 2012 at 10:00 a.m.
Due Date for Questions:	May 25, 2012 at 12:00 noon
Response Due Date:	May 29, 2012 at 3:00 p.m.
Proposal Due Date:	June 1, 2012 at 10:30 a.m.
Award shall be made by:	June 22, 2012
Contract begins:	July 1, 2012

REINSURANCE BID SPECIFICATIONS

Proposal Submission Instructions

All applicable experience data that is available is included in this proposal package. Should any additional data become available during the proposal process we will immediately forward the information to all proposers.

RFP Documents will be available on line at: **www.newtonma.gov/bids ,** under the Invitation for Bid link or pickup at the Purchasing Department **after 10:00 a.m., May 17, 2012.** There will be no charge for contract documents.

Completed Proposals shall be submitted no later than **10:30 a.m. on June 1, 2012**.
Proposals shall be delivered to: *Chief Procurement Officer*, Room 204, City of Newton, 1000 Commonwealth Avenue, Newton, MA 02459. Please ensure that **"Technical" & "Price" Proposals are submitted in separate sealed envelopes.** Any Technical Proposal received with Price Proposal information shall be cause for rejection. Technical Proposal shall be in a sealed envelope clearly marked "**RFP #12-77 Technical Proposal for Reinsurance Coverage".**

Please ensure you've acknowledged any/all addendum that have been issued for this RFP in both Technical and Price Proposals.

The **"Price Proposal"** shall be submitted on the forms included herein as **Attachment F**. The price proposals must be submitted in a **separate sealed envelope** clearly marked "**Price Proposals for RFP No. 12-77 Reinsurance Coverage.**" No reference to cost may be made in any other section of your proposal. Proposers shall submit the following:

- **Two copies of the proposal for the "Technical" portion of the RFP**
- **One copy of the proposal for the "Price" portion of the RFP**

Proposers are encouraged to quote on each of the attachment point options specified on the price pages.

The City shall award a contract based on the most advantageous proposal, price and evaluative criteria considered. The City shall select the attachment point and run-out option at its discretion and as may be in the public interest.

Current Reinsurance Coverage and Plan Design:

Reinsurance is currently provided by Westport Insurance Corporation and covers the City's medical benefits administered by both Tufts Health Plan and Harvard Pilgrim. It includes the prescription drug benefits administered by both plans. The attachment point is $250,000 specific.

The current plans administered by Tufts are an EPO Plan which only allows utilization of in-network providers, and a POS Plan in which utilization of in-network providers has been at 94.8% with the exception of the Out-of-Network subset (see #1 below). The City has introduced a PPO plan starting in August for City employees, and December for School employees.

The Tufts POS Plan includes the following feature:

> Out of Area Group - The Out-of-Area Group is a subset of the Point of Service Plan. Members in this group have all of their claims processed as though all the providers are in the network. (All claims are paid at 100% of the Usual and Customary amount.) Members are responsible for any balanced billing. Less than 1% of claims submitted by this group are with network providers. There are 53 Individual and 23 Family contracts in the Out of Area Group.

1) All Harvard Pilgrim Claims are in network.

2) There are no lifetime maximums with either the PPO/POS/OOA or EPO Plan.

3) The plan design for the plan year starting July 1, 2012 will remain unchanged from the current plan year.

4) Prescription coverage includes optional Mail Order coverage along with pharmacy coverage.

5) The City also now utilizes the purchase of Canadian drugs for its members. This program is not to be included in this bid.

6) The City is not able to provide a census that includes zip codes.

7) The attachments listed below are included in the bid package.

Attachment A - Current Reinsurance Rates and policy limits
Attachment B - Subscriber/member demographic profile for Tufts and HP
(All Ages listed are as of April 1, 2012)
Attachment C - Enrollment/Claims monthly history since FY 09 for Tufts and
Since FY 09 for Harvard
Attachment D - Large Claims of prior years and current year (over $100,000)
Attachment E - Plan Benefit Summaries
Attachment F - Price Proposal Submission Form (**To be submitted separately**)
Attachment G – Statement of Compliance – To be included in bid.
Attachment H - Rate History and Miscellaneous Information

Award Decision Criteria:

In order to be considered for a Group Reinsurance and Reporting contract award, a proposal must be complete with all submission requirements met and with responses submitted on forms provided, and must meet the Contractual Requirements as set forth in this Request for Proposal. From among those complete and correctly submitted proposals meeting the requirements and specifications, the Contract will be awarded based on the selection criteria in this Request for Proposals.

Purchaser's Rights:

The City reserves the right to accept or reject any and all proposals.

The City reserves the right to reject any proposal which does not comply with any and all applicable state and federal statutes.

The City reserves the right to reject any proposal, which does not meet the requirements. The City will be the sole judge of whether or not a proposal meets these Requirements, and the City's decision will be final.

The City reserves the right to reject any proposal which is not submitted according to the prescribed format, not properly signed or otherwise contrary to instructions.

The City reserves the right to reject any and all proposals if there is reason to believe that collusion exists among the brokers/carriers.

The City reserves the right to independently verify the accuracy of information supplied in the proposals.

The City reserves the right to reject any proposal which is subject to final underwriting approval and/or which does not ultimately meet contractual requirements as stated in the general requirements.

The City reserves the right to select the final attachment point from among the submitted attachment points.

Information prepared and submitted by Proposers in response to this Request for Proposals shall be the property of the City of Newton.

Items Required to Be Submitted With Proposal:

(1) Letter of Transmittal - Letter from authorized representative of carrier binding the carrier to the contractual requirements and to rates for 60 days from the proposal due date.

(2) Price proposals submitted on Attachment F, and meeting specifications of this Request for Proposal. Attachment F must be provided in a **separate sealed envelope and prices must not be mentioned anywhere in the technical proposal.**

(3) Signed Attestation (Form provided)

(4) Statement of Compliance. See Attachment G

General Requirements:

Proposals must include the following:

1. Letter of transmittal signed by the individual authorized to negotiate for and contractually bind the carrier, stating that the offer is effective for at least sixty (60) days from the deadline for the submission of the proposals (effective date of policy is July 1, 2012). The letter should also state the proposer's understanding of the coverage to be provided; and make a positive commitment to provide the coverage under the contractual requirements specified in this Request for Proposals within the required policy period.

2. Signed Attestation (Form enclosed).

3. A list with names, addresses, and phone numbers of contact persons of Massachusetts municipalities for which the Broker and Carrier are currently contracted to provide similar services. Please provide accounts with 500 or more covered subscribers.

4. All price proposals shall be submitted on **Attachment F** of this proposal and be submitted in a separate sealed envelope. They shall be on the incurred/paid basis specified on **Attachment F.**

5. The broker/stop loss administrator selected through this process will be required to conform to the reporting and other service requirements specified in this Request for proposals unless the City of Newton exercises its right to engage an independent stop loss tracking, filing and reporting firm.

6. All proposals must provide reinsurance coverage for Tufts POS, Tufts PPO, Tufts EPO and Harvard Pilgrim HMO.

7. All proposals must provide reinsurance for all members of the plans named in item #6 above, i.e. employees, retirees, and dependents.

8. Reimbursement factor: All proposals must provide a reimbursement factor of 100% of covered medical expenses and prescription drug coverage subject to applicable plan maximums.

9. Lifetime Maximum: All policies proposed must provide a minimum of a lifetime Maximum benefit payable of $2 million per claimant.

10. Proposals must describe stop loss Claims Tracking, Filing, and Reporting services. Proposals must include a detailed description of the process by which claims will be monitored and tracked including the names of the company (ies) that will track and file the claims with the carrier. (The City of Newton reserves the right to engage an independent claims tracking, filing and reporting company.)

11. Proposals must describe how information on status of claims with potential to reach the stop loss deductible and information on status of claims exceeding the deductible will be reported to the City of Newton.

    Proposals must include provisions for monthly reporting of the following data:

    For the monthly report of claims at or above 50% of the deductible:

    Claimant name, coverage ID number, dollar amount of claims incurred during the policy period, dollar amount under the deductible, month and year of most recent paid claims data reviewed for this report.

For the monthly report of claims at or above the stop loss deductible:

Claimant name, coverage ID number, dollar amount of claims incurred to date during the policy period, dollar amount exceeding the deductible, dollar amount of claims detail submitted to reinsurance carrier, outstanding detail to be submitted, dollar amount of reimbursement to date, dollar amount of outstanding reimbursements, month and year of most recent paid claims data reviewed for this report.

Proposals must include sample reports and confirm in the proposal that reports will be sent to the City of Newton or its designees each month beginning in September 2010 and throughout the run-out period(s) of the policy(ies). If there is no activity for a particular month, the stop loss tracker and filer is required to supply a "Report of No Activity" stating the most recent paid claims data reviewed.

12. Proposals must comply with all applicable federal and state statutes.

Note: A proposal from a non-admitted carrier will not be considered and will not be accepted unless there is no proposal submitted from an admitted carrier.

13. Proposers are requested to provide a retrospective rebate proposal (or comparable proposal such as up-front discounted premium arrangement) that would apply if claims paid by the reinsurance carrier are 50% or less of premium.

Services To Be Provided:

The successful proposer will provide, for the service period bided, stop-loss coverage for the City of Newton's self-insured health plans. The selected vendor will be responsible for exchanging and verifying information with the Tufts Total Health Plan and Harvard Pilgrim Health Care concerning claims near or exceeding the selected attachment point. It will be the sole responsibility of the vendor to develop a working relationship with Tufts and Harvard Pilgrim that produce accurate and timely information and allows the City to be reimbursed promptly.

Who Can Bid and Policy Regarding Brokers:

Both insurance companies and brokers can bid directly, but in our twenty plus years of bidding for Stop Loss, an insurance company has never submitted a bid.

The City's policy regarding brokers is as follows:

The City of Newton has a policy of not having a Broker of Record for the City. For all bids, it is neither in favor of nor opposed to having brokers participate in the bidding process. It will accept all bids, directly from insurance companies and from brokers and evaluate them based upon their merit and their cost. It will not provide letters of authorization to any brokers. In the case of the same winning bid being provided by an insurance company and/or one or more brokers, the Director of Human Resources, in consultation with the Director of Purchasing and the Law Department, will make the decision as to which bid is the most advantageous for The City of Newton, and which one will be awarded.

Bid Requirements:

Proposers shall state therein that their proposal acknowledges and incorporates as required each of the items listed below.

1. The effective date will be July 1, 2012.

2. The current contract reflects an incurred in 12 months, paid in 18 months basis. Quotes are being sought on an incurred in 12 months and paid in 18 month basis for Tufts EPO, POS, PPO and Harvard Pilgrim HMO.

3. Proposers must clearly state any restrictions or deviations from these specifications. In the absence of such statement, the City shall assume that all items offered are in strict compliance with the technical and financial requirements, and contract terms and conditions described in these specifications. The proposal of the successful proposer will be included as an appendix to the final contract.

4. Enrollees include actives, disabled, COBRA beneficiaries, employees on approved leave of absences, early retirees, and retirees over the age 65 ineligible for Medicare.

5. Actively-at-work requirements and any pre-existing condition exclusions must be waived for current and future participants.

6. Rates should be quoted on a two-tiered basis (i.e. single and family). Any commissions, placement fees, administrative charges or other charges to the City must be included in the rates quoted.

7. The City has a mail order prescription plan as part of its drug program administered by Caremark for Tufts EPO, POS and PPO. Please refer to attachments for plan design.

8. The Harvard Pilgrim Plan also offers a mail service prescription drug program.

9. Quoted rates should assume the City pays premiums on a monthly basis.

10. Proposals cannot include restrictions or contingencies regarding specific subscribers/members (e.g. those with ongoing claims).

11. Quoted rates will be firm regardless of changes to enrollment for the new plan year.

12. Coverage will provide 100% reimbursement once specific stop-loss levels are reached up to the lifetime maximum.

13. Coverage has no limitations for specific illnesses or physical conditions.

14. All quotes will be considered valid for at least sixty (60) days from the deadline for the submission of the proposals.

15. This bid will be awarded by June 22, 2012.

16. All prices and proposals will be considered final and non-negotiable.

17. QUESTIONS: Inquiries involving procedural or technical matters shall be received in writing, no later than **12:00 noon, May 25, 2012 to:**

City of Newton - Purchasing Dept.
Chief Procurement Officer
1000 Commonwealth Avenue
Newton, MA 02459

FAX (617) 796-1227 or
E-mail: purchasing@newtonma.gov

18. It is the responsibility of each proposer to ensure that they have received and acknowledge any/all addendum with regards to this RFP. Anyone on record as having received this RFP will be faxed the addendum automatically. If you have downloaded this RFP from the City's website, you must email: **purchasing@newtonma.gov** or fax us your company's name, address, phone, and fax as well as the BID/RFP number and project title.

Vendor Minimum Requirements:

In order to be considered an eligible proposer, all respondents must answer "Yes" to the following questions and be prepared to provide supporting documentation as required by the City. In providing responses, proposers must restate the question and provide an answer with supporting information as required.

1) Has the re-insurer been in the reinsurance marketplace for at least five years?

Yes: _____ No: _____

2) Can the re-insurer verify that it has a record of paying promptly all properly submitted claims?

Yes: _____ No: _____

3) Can the re-insurer verify that there have been no claims paid late or that have gone unpaid due to insufficiency of funds?

Yes: _____ No: _____

4) Are all of the re-insurer's sources of financial support (those entities ultimately responsible for guaranteeing the availability of funds to pay claims) rated by a recognizing rating agency (Moody's or A. M. Best, for example)?

Yes: _____ No: _____

5) Is the re-insurer evaluated by a recognizing rating agency (Moody's or A. M. Best, for example)?

Yes: _____ No: _____

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Selection Criteria:

Price will not be the only criteria upon which the City of Newton makes its selection of reinsurance carrier. The following criteria will apply:

- Meets the vendor minimum requirements;
- Conformance to the specifications of this Request for Proposals including all required contractual provisions specified in Exhibit A, and completeness of responses;
- Insurance company ratings and claims administration ratings;
- Price and attractiveness of one-year versus two-year proposal and attractiveness of specific deductible proposals;
- Experience and quality of service to clients as reported by Proposer and by References in providing coverage to accounts (including amount of Massachusetts business, dollars paid in stop loss reimbursements, experience in administering policy over multiple carriers/health plans;
- Turn-around time for reimbursement and availability of immediate reimbursement arrangements;
- Comprehensiveness and timeliness of reporting to accounts, and general level of service in the above as reported by References;
- Acceptance of the City of Newton claims administrators: Harvard Pilgrim Health Care, and Tufts Total Health Plan;
- Status as an admitted carrier in Massachusetts;
- Demonstrated experience or knowledge of the Massachusetts municipal sector;
- Stop loss claims tracking, monitoring, and filing capabilities;
- Demonstration of financial arrangements beneficial to the City of Newton;
- Optional contract terms which are favorable to the City of Newton.

The above criteria will be applied to proposals to select the policy with the highest value for the City of Newton.

The City of Newton is not required by law to seek competitive quotes for Insurance Coverage. When it does decide to seek competitive quotes for insurance, it is not required to follow any specified procedure or laws.

The City of Newton will be the sole judge of whether or not a proposal meets the criteria of the Request for Proposal, and its decision shall be final.

The City of Newton will be the sole judge of whether or not a particular proposal has the highest value for the City of Newton compared to other proposals based on the selection criteria, and its decision shall be final.

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PROPOSER'S QUESTIONNAIRE

All Respondents must answer the following questions and requests in writing in order to be considered in the selection process.

Submit this completed questionnaire with your "Technical Proposal".
Please include additional sheets for your answers if necessary.

NAME OF RESPONDING COMPANY AND PROPOSED CARRIER MUST BE ON EACH PAGE OF THIS QUESTIONNAIRE.

Proposer acknowledges the following addendum: _____, _____, _____, _____, _____

1. What is the full legal name and address of the entities proposing to provide group medical reinsurance to the City of Newton

   Carrier: _____

   Broker: _____

   Managing General Underwriter (MGU): _____

   Stop Loss Administrator: _____

   Entity responding to this RFP: _____

2. Is the reinsurance carrier for which you have submitted a proposal an admitted carrier in the Commonwealth of Massachusetts? Yes _____; No _____

3. What is the number of reinsurance contracts in Massachusetts that are currently being placed by the broker named above?
   _____
   _____

4. Describe how your stop-loss charges are calculated.
   _____
   _____

5. Please give assurance that there will be no special underwriting for high cost claimants, i.e. no "lasering" will occur, and please specify the standards the carrier uses to define "experimental procedures."
   _____
   _____
   _____
   _____
   _____

6. Describe your process for reimbursement under your contract. Please include an explanation of the process you follow for paying and reviewing claims. How long does reimbursement take after you receive the required documentation?
   _____
   _____

Name of responding company: _____
Name of proposed carrier: _____

7. Describe your liability for specific reimbursement upon contract termination, for both on-and-off anniversary dates.

_____
_____

8. Describe your premium payment procedures and include copies of all applicable forms.

_____
_____

9. Please identify any reimbursement maximums under the proposed specific stop-loss arrangement (e.g., per year, per participant, per contract).

_____
_____

10. Please describe any other limits under your stop-loss agreements (e.g., mental/nervous).

_____
_____

11. Please describe any other funding alternatives or contract forms that you wish to have considered.

_____
_____

12. What was the most recent Standard & Poors, Best, Moody's Duff & Phelps and/or other relevant rating assigned to the reinsurance carrier that you are proposing which demonstrates financial stability, as well as the respective rating which is assigned to the claim paying ability of the carrier? Please provide the date of the rating.

_____
_____
_____
_____

13. Please provide copies of your specimen contract and any amendments needed to put this contract in conformance with the contractual requirements specified herein.

_____
_____

14. Please provide non-confidential information on reinsurance claims you as Broker/Carrier have paid for Massachusetts clients, for example, total dollar amount paid to Municipalities and School Districts for the past three years, if any.

_____
_____
_____
_____

15. What is the carrier's average turn-around-time for payment of claims once claims detail has been submitted to the carrier?

_____
_____

16. Does the broker receive compensation other than commissions (i.e. does broker earn fees depending upon the carrier's loss ration)?

Yes _____ No _____

17. Please describe the experience the stop loss tracking and filing firm has had in stop loss claims administration.

_____
_____

Name of responding company: _____
Name of proposed carrier: _____

18. Will the proposed carrier reimburse the City of Newton based on the basis of payment to the providers used by the claims administrators as opposed to the lesser of charges or basis of payment?

Yes _____ No _____

19. Do you confirm that the quotations for reinsurance submitted herein are good for 60 days from the due date of proposal?

Yes _____ No _____

20. Please include the names of five references who can be contacted to comment on your reinsurance coverage. Massachusetts' employers contracting with Tufts Total Health Plan and/or Harvard Pilgrim Health Care are preferred.

_____
_____

21. Provide a statement explaining any and all litigation pending against the proposer arising from reinsurance or related services.

_____
_____

22. Provide verification that the proposer retains appropriate liability coverage for errors, omissions, and similar occurrences.

_____
_____

23. All parties that are assuming risk in reinsurance coverage must be identified. Please provide the party's name, share of the risk, and their level of risk exposure (primary, secondary, etc.).

_____
_____

24. Alternative funding arrangements will be considered. Please provide complete details if responding with a non-standard funding approach.

_____
_____

25. Sample standard reports and specimen agreements and coverage schedules should be included in your proposal.

_____
_____

By my signature below, I certify that the responses provided herein to this Questionnaire of the City of Newton's "Request for Proposals for Group Reinsurance and Reporting" are true and accurate and that materials provided by my company in response to this Request for Proposals are a fair and accurate representation of the proposed reinsurance policy, procedures, and services that will be provided to the City of Newton if accepted.

_____ _____

(Authorized Representative of Carrier) *(Date)*

Name of responding company: _____
Name of proposed carrier: _____

ATTESTATION

Pursuant to MG c. 62C, § 49A, the undersigned acting on behalf of the Contractor, certifies under the penalties of perjury that, to the best of the undersign's knowledge and belief, the Contractor is in compliance with all laws of the Commonwealth relating to taxes, reporting of employees and contractors, and withholding and remitting child support.*

_____ _____

**Signature of Individual or Corporate Contractor (Mandatory)

*** Contractor's Social Security Number (Voluntary) or Federal Identification Number

By: _____
Corporate Officer
(Mandatory, if applicable)

Date: _____

* The provision in the Attestation relating to child support applies only when the Contractor is an individual.

** Approval of a contract or other agreement will not be granted unless the applicant signs this certification clause.

*** Your social security number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Providers who fail to correct their non-filing or delinquency will not have a contract or other agreement issued, renewed, or extended. This request is made under the authority of GL c. 62C, § 49A.

CERTIFICATION REGARDING LOCAL TAXES

The undersigned acting on behalf of the Contractor, certifies under the penalties of perjury that, to the best of the undersign's knowledge and belief, the Contractor has paid all local taxes, fees, assessments, betterments, or any other municipal charge, unless the Contractor has a pending abatement application or has entered into a payment agreement with the City of Newton collector-treasurer.

_____ _____

*Signature of Individual
or Corporate Contractor (Mandatory)

** Contractor's Social Security Number
(Voluntary) or Federal Identification Number

By: _____ Date: _____
Corporate Officer
(Mandatory, if applicable)

* Approval of a contract or other agreement will not be granted unless the applicant signs this certification clause.
** Your social security number will be furnished to the City of Newton Treasurer-Collector to determine whether you have paid all local taxes or fees to the City. Providers who fail to correct their non-filing or delinquency will not have a contract or other agreement issued, renewed, or extended.

ATTACHMENTS

ATTACHMENT – A (1 page)

ATTACHMENT – B (4 pages)

ATTACHMENT – C (4 pages)

ATTACHMENT – D (14 pages)

ATTACHMENT – E (19 pages)

ATTACHMENT – F (1 page)

ATTACHMENT – G (2 pages)

ATTACHMENT – H (1 page)

Attachment A – Page 1

The City of Newton
For Tufts EPO, POS, PPO and Harvard Pilgrim HMO

Current Re-Insurance: (July, 2011 thru June, 2012)	Westport Insurance Corporation through Stop Loss Insurance Brokers
Type of Insurance:	Specific
Attachment Point:	$250,000
Incurred/Paid:	12 / 18
Individual Rate:	$8.03 per Month
Family Rate:	$21.08 per Month
Pre-Existing Exclusions:	None
Waiting Period:	None
Lifetime Maximum:	$2,000,000
Mental/Nervous Exclusion:	None
Prescription Coverage:	Included

Attachment B – Page 1

Tufts Plan

For City of Newton
As of April, 2012

INDIVIDUAL CONTRACTS

Subscribers:

Age Range	Male	Female	Total
0-10	0	1	1
11-20	1	1	2
21-30	55	102	157
31-40	79	92	171
41-50	41	46	87
51-60	41	78	119
61-70	82	183	265
70+	38	65	103

Members:

Age Range	Male	Female	Total
0-10	0	1	1
11-20	1	1	2
21-30	55	102	157
31-40	79	92	171
41-50	41	46	87
51-60	41	78	119
61-70	82	183	265
70+	38	65	103

Attachment B – Page 2

Tufts Plan

For City of Newton
As of April, 2012

FAMILY CONTRACTS

Subscribers:

Age Range	Male	Female	Total
0-10	0	0	0
11-20	0	0	0
21-30	7	15	22
31-40	78	92	170
41-50	118	120	238
51-60	171	170	341
61-70	137	109	246
70+	8	8	16

Members:

Age Range	Male	Female	Total
0-10	231	211	475
11-20	288	246	546
21-30	203	200	229
31-40	157	181	368
41-50	219	251	458
51-60	305	347	691
61-70	254	201	352
70+	31	15	39

Attachment B – Page 3

Harvard Pilgrim Plan
For City of Newton
As of April, 2012

INDIVIDUAL CONTRACTS

Subscribers:

Age Range	Male	Female	Total
0-4	0	0	0
10-19	0	1	1
20-29	40	81	121
30-39	46	102	148
40-49	22	26	48
50-59	32	30	62
60-64	26	55	81
65+	7	21	28

Members:

Age Range	Male	Female	Total
0-4	0	0	0
10-19	0	1	1
20-29	40	81	121
30-39	46	102	148
40-49	22	26	48
50-59	32	30	62
60-64	26	55	81
65+	7	21	28

Attachment B – Page 4

Harvard Pilgrim Plan
For City of Newton
As of April, 2012

FAMILY CONTRACTS

Subscribers:

Age Range	Male	Female	Total
0-4	0	0	0
5-14	0	0	0
15-29	2	8	10
30-39	69	83	162
40-49	62	66	139
50-59	71	77	149
60-64	48	47	98
65+	10	7	13

Members:

Age Range	Male	Female	Total
0-4	82	76	177
5-19	225	208	445
20-29	84	79	156
30-39	130	152	288
40-49	124	135	276
50-59	133	144	287
60-64	91	83	253
65+	25	12	31

Attachment C – Page 1

Month	Tufts EPO	Enrollment I	Enrollment F	Tufts POS	Enrollment I	Enrollment F
			FY 09 Claims			
July, 2008	$1,743,606	675	810	$573,597	227	216
August, 2008	$1,246,563	672	809	$585,266	229	216
September, 2008	$1,644,224	641	804	$604,642	219	211
October, 2008	$1,437,216	639	803	$655,941	217	209
November, 2008	$1,494,488	677	814	$587,097	221	208
December, 2008	$1,506,012	672	816	$530,760	224	207
January, 2009	$1,243,630	671	814	$470,026	225	204
February, 2009	$1,420,514	672	819	$508,865	222	204
March, 2009	$1,705,308	678	818	$570,368	218	205
April, 2009	$1,397,374	679	818	$432,674	218	205
May, 2009	$1,294,575	679	816	$429,199	218	204
June, 2009	$1,684,707	682	815	$579,037	212	203

Attachment C – Page 2

Month	Tufts EPO	Enrollment I	Enrollment F	Tufts POS	Enrollment I	Enrollment F
			FY 10 Claims			
July, 2009	$1,441,990	680	814	$468,716	212	201
August, 2009	$1,502,480	687	823	$385,445	204	210
September, 2009	$1,883,991	687	818	$625,478	200	207
October, 2009	$1,296,864	696	820	$372,909	195	204
November, 2009	$1,267,235	732	827	$533,041	192	204
December, 2009	$1,696,314	741	827	$508,291	194	204
January, 2010	$1,696,225	737	830	$491,108	192	201
February, 2010	$1,405,611	738	833	$576,252	192	202
March, 2010	$2,011,556	743	830	$656,797	189	201
April, 2010	$2,014,494	744	828	$671,498	194	200
May, 2010	$2,600,340	739	827	$866,780	194	200
June, 2010	$1,411,419	744	824	$607,750	194	202

FY 11 Claims

Month	Tufts EPO	Individual enrollment	Family enrollment	Tufts POS	Individual enrollment	Family enrollment
July 2010	$1,518,513.33	733	818	$420,734.81	189	203
August 2010	$2,131,312.50	734	829	$627,021.64	188	202
September 2010	$1,567,810.88	706	834	$508,046.47	187	199
October 2010	$1,673,256.04	698	827	$496,586.86	186	202
November 2010	$1,875,281.09	746	838	$781,130.26	182	207
December 2010	$1,508,074.67	755	834	$439,137.39	186	207
January 2011	$1,508,999.13	760	835	$543,774.01	187	204
February 2011	$1,634,474.04	761	837	$461,396.25	185	207
March 2011	$1,614,071.84	756	830	$516,979.27	182	205
April 2011	$1,678,478.01	753	825	$470,556.34	181	205
May 2011	$1,487,092.39	748	817	$388,821.95	179	205
June 2011	$1,805,080.92	751	812	$712,488.18	177	206

FY 12 Claims

Month	Tufts EPO	Individual enrollment	Family enrollment	Tufts POS/PPO	Individual enrollment	Family enrollment
July 2011	$1,560,717.54	741	816	$484,392.85	177	205
August 2011	$1,847,922.89	735	825	$540,286.03	175	204
September 2011	$1,391,158.59	702	832	$461,785.41	166	186
October 2011	$1,741,589.09	721	844	$591,762.40	169	187
November 2011	$1,625,964.10	749	858	$504,523.04	164	189
December 2011	$1,254,079.35	743	848	$473,525.31	159	190
January 2012	$1,657,857.47	752	877	$434,789.02	150	169
February 2012	$1,929,986.62	756	877	$519,708.97	149	171
March 2012	$1,650,784.50	754	876	$474,991.03	146	166
April 2012	$1,488,389.86	755	876	$322,048.08	150	161
May 2012		752	873		149	160
June 2012						

Attachment C – Page 3

FY09 Claims

Month	Harvard Pilgrim HMO	Individual enrollment	Family enrollment
July 2008	$1,153,918	668	553
August 2008	$869,813	660	557
September 2008	$968,637	581	542
October 2008	$1,123,807	578	555
November 2008	$855,575	601	570
December 2008	$1,364,886	607	570
January 2009	$1,146,021	603	573
February 2009	$983,218	610	573
March 2009	$982,602	613	567
April 2009	$1,496,988	612	572
May 2009	$1,085,423	611	575
June 2009	$1,070,510	610	575

Attachment C – Page 4

FY10 Claims

Month	Harvard Pilgrim HMO	Individual enrollment	Family enrollment
July 2009	$1,384,278	595	576
August 2009	$821,665	594	577
September 2009	$949,383	593	579
October 2009	$1,078,011	584	584
November 2009	$1,064,497	600	589
December 2009	$963,279	593	590
January 2010	$896,633	599	591
February 2010	$762,661	604	593
March 2010	$919,631	604	595
April 2010	$878,515	598	597
May 2010	$885,882	599	593
June 2010	$1,318,714	598	593

FY11 Claims

Month	Harvard Pilgrim HMO	Individual enrollment	Family enrollment
July 2010	$1,175,113	593	578
August 2010	$903,358	583	578
September 2010	$1,093,552	552	568
October 2010	$970,600	549	578
November 2010	$1,509,141	568	580
December 2010	$1,067,232	570	583
January 2011	$878,939	568	581
February 2011	$856,908	567	577
March 2011	$1,312,472	559	571
April 2011	$1,039,786	552	571
May 2011	$845,554.84	549	570
June 2011	$1,040,043.44	549	566

FY12 Claims

Month	Harvard Pilgrim HMO	Individual enrollment	Family enrollment
July 2011	$920,285.98	549	566
August 2011	$1,108,422.09	549	566
September 2011	$617,807.04	497	566
October 2011	$796,635.59	496	551
November 2011	$1,122,533.10	496	557
December 2011	$862,525.73	502	556
January 2012	$532,792.73	494	554
February 2012	$980,132.86	489	551
March 2012	$872,165.70	489	549
April 2012	$827,203.60	487	548
May 2012		485	550
June 2012			

Attachment D – Page 1

City of Newton
Tufts Total Health – Payments in excess of $125,000
July 1, 2008 through June 30, 2009

Sex	Relation	Payment	Plan	Current Status	Diagnosis	Prognosis	DOB
F	Subscriber	$390,989	EPO	Died 12/22/2008			01/36/1930
F	Subscriber	$168,036	POS	Died 11/01/2008			12/18/1949
M	Subscriber	$204,405	EPO	Died 09/21/2009			03/25/1971
F	Spouse	$140,992	EPO	Died 09/20/2008			02/05/1932
M	Subscriber	$133,461	EPO	Term 8/21/2009	Mitral Valve Disorder	Stable Costs expected to Decrease	10/10/1951
M	Spouse	$193,849	EPO		Subdural Hematoma	Stable Costs expected to Decrease	12/16/1940
F	Spouse	$114, 181	EPO		Lung Disease	Stable Costs expected to Decrease	07/08/1949
M	Subscriber	$107,297	EPO		Pulmonary Emboli	Stable Costs expected to Decrease	12/20/1946
M	Subscriber	$168,193	POS		Cardiac Disease	Stable Costs expected to Decrease	02/16/1947
M	Subscriber	$171,982	EPO				05/26/1945

Attachment D – Page 2

City of Newton
Tufts Total Health – Payments in excess of $100,000
July 1, 2009 through June 30, 2010

Sex	Relation	Payment	Plan	Current Status	Diagnosis	Prognosis	DOB
M	S	$118,404	EPO	Active	Toxic Encephalopathy	Stable	11/22/1950
F	M	$116,352	POS	Active	Subendo Initial Episode	Stable	01/16/1948
M	S	$205,393	EPO	Active	Abscess of Appendix	Stable	12/20/1946
F	M	$146,306	EPO	Active	Of Native Coronary Artery	Stable	5/12/1956
F	M	$119,074	POS	Termed	Secondary Malignant Neo Lung		11/16/1946
F	S	$127,231	EPO	Termed	Enc Antineoplastic Chemo		2/18/1948
F	M	$130,980	EPO	Termed	Hepatorenal Syndrome		2/18/1966
F	S	$155,215	POS	Termed	Malign Neopl Breast NEC		8/8/1954
M	S	$398,060	POS	Active	Malig Neo Supraglottis	Stable	2/16/1947
F	S	$157,972	EPO	Active	Malign Neopl Breast NEC	Stable	1/30/1950
F	M	$139,390	EPO	Termed	Mal Neo Bronch/Lung NOS		5/5/1954
M	S	$137,423	EPO	Termed	Sec Mal Neo Brain/Spine		3/25/1971
M	S	$130,568	EPO	Active	Enc Antineoplastic Chemo	Stable	11/10/1959
M	S	$112,525	POS	Active	Cervical Spinal Stenosis	Stable	10/18/1949
M	S	$106,182	EPO	Termed	Acute Resp Failure		5/28/1936
M	M	$129,714	EPO	Active	Enc Antineoplastic Chemo	Stable	2/25/1951
M	M	$115,269	EPO	Active	Gastroparesis	Stable	9/24/1946
F	S	$101,367	EPO	Termed	Recurr Depr Psychos-MOD		6/28/1945

Attachment D – Page 3

City of Newton
Tufts Total Health – Payments in excess of $100,000
July 1, 2010 through March 31, 2011

Sex	Relation	Payment	Plan	Current Status	Diagnosis	Prognosis	DOB
F	S	$180,642	EPO	Active	Diverticulitis of Colon	Stable	11/22/1950
F	M	$115,458	POS	Active	Enc Antineoplastic Chemo	Stable	2/7/1950
F	M	$268,197	POS	Active	Reg Enterit SM/LG Intest	Stable	9/19/1968
M	S	$179,113	POS	Active	Mitral Valve Disorder	Stable	10/10/1949
M	S	$114,137	EPO	Active	Subendo Initial Episode	Stable	11/10/1929
F	S	$121,015	POS	Active	Mitral Valve Disorder	Stable	7/2/1946
F	S	$101,126	EPO	Active	Occl & Sten W Cereb Infa	Stable	12/12/1936
F	M	$135,764	EPO	Active	Benign Neo Cranial Nerve	Stable	6/10/1957
F	S	$115,784	EPO	Active	Enc Antineoplastic Chemo	Stable	7/1/1945
M	M	$116,352	EPO	Active	Acute & Chronice Resp Fai	Stable	12/5/1945
F	S	$206,817	EPO	Termed	Enc Antineoplastic Chemo		10/20/1951
F	S	$221,258	POS	Active	Staphylococcus Aureus Se	Stable	4/21/1946
F	S	$159,372	EPO	Active	Enc Antineoplastic Chemo	Stable	12/16/1953

Tufts Total Health – Payments in excess of $100,000
July 1, 2011 through March 31, 2012

Sex	Relation	Payment	Plan	Current Status	Diagnosis	Prognosis	DOB
M	S	$146,540	POS	Active	Other Streptococcus	Stable	8/27/1949
F	M	$131.732	POS	Active	Hemoperitoneum	Same	7/16/1947
M	S	$168,936	EPO	Active	Radiotherapy Session	Same	4/28/1938
F	S	$103,177	EPO	Termed	Enc Antineoplastic Chemo		12/16/1953
F	M	$188,103	EPO	Active	Malign Neopl Breast NOS	Same	5/17/1950
M	S	$149,034	EPO	Active	Beo Neo Cerebr Meninges	Same	12/9/1973

Attachment D – Page 4

Cutoff Amount: 100,000
Cost Logic: CU / Cost and Utilization Paid Logic
Incurred Period: 2008-07-01 to: 2009-06-30
Paid Period: 2008-07-01 to: 2010-02-28
Group/Division Numbers: 065710 / All Divisions
Harvard Pilgrim Health Care

Claimant 1	Neoplasms	Termed	$270,525.96
Claimant 2	Classification of Factors Influencing Health Status & Contact with Health Service	Active	$248,494.15
Claimant 3	Neoplasms	Active	$233,731.95
Claimant 4	Infectious and Parasidic Diseases	Active	$192,835.19
Claimant5	Diseases of the Circulatory System	Active	$179,582.20
Claimant 6	Diseases of the Genitourinary System	Active	$173,722.41
Claimant 7	Diseases of the Circulatory System	Active	$156,335.21
Claimant 8	Certain Causes of Perinatal Morbidity and Mortality	Termed	$149,632.45
Claimant 9	Neoplasms	Termed	$144,792.54
Claimant 10	Neoplasms	Active	$137,771.99
Claimant 11	Diseases of the Circulatory System	Active	$135,400.20
Claimant 12	Diseases of the Circulatory System	Active	$115,336.23
Claimant 13	Diseases of the Circulatory System	Active	$113,637.47

Attachment D – Page 5

Cutoff Amount: 100,000
Cost Logic: CU / Cost and Utilization Paid Logic
Incurred Period: 2009-07-01 to: 2010-06-30
Paid Period: 2009-07-01 to: 2011-03-31
Group/Division Numbers: 065710 / All Divisions
Harvard Pilgrim Health Care

Claimant 1	Classification of Factors Influencing Health Status & Contact with Health Service	Active	$179,300.33
Claimant 2	Classification of Factors Influencing Health Status & Contact with Health Service	Active	$160,772.75
Claimant 3	Neoplasms	Active	$142,703.62
Claimant 4	Diseases of the Circulatory System	Termed	$131,983.18
Claimant 5	Diseases of the Genitourinary System	Active	$128,640.69
Claimant 6	Classification of Factors Influencing Health Status & Contact with Health Service	Active	$123,651.01
Claimant 7	Neoplasms	Active	$102,679.89

Cutoff Amount: 100,000
Cost Logic: CU / Cost and Utilization Paid Logic
Incurred Period: 2010-07-01 to: 2010-01-31
Paid Period: 2010-07-01 to: 2011-03-31
Group/Division Numbers: 065710 / All Divisions
Harvard Pilgrim Health Care

Claimant 1	Injury and Poisoning	Active	$241,468.53
Claimant 2	Diseases of the Circulatory System	Active	$171,852.92
Claimant 3	Diseases of the Circulatory System	Active	$133,181.78
Claimant 4	Endocrine, Nutritional, and Metabolic Diseases And Immunity Disorders	Active	$130,531.04
Claimant 5	Diseases of the Nervous Systems and Sense Organs	Active	$126,679.22

Cutoff Amount: 100,000
Cost Logic: CU / Cost and Utilization Paid Logic
Incurred Period: 2011-07-01 to: 2012-01-31
Paid Period: 2011-07-01 to: 2011-03-31
Group/Division Numbers: 065710 / All Divisions
Harvard Pilgrim Health Care

Claimant 1	Injury and Poisoning	Active	$249,109.42
Claimant 2	Diseases of the Digestive System	Active	$209,071.33
Claimant 3	Classification of Factors Influencing Health Status And contact with Health Service	Active	$185,315.00

Schedule of Benefits
The Harvard Pilgrim HMO
Services listed are covered when medically necessary and provided or arranged by Harvard Pilgrim Health Care Providers. Please see your Benefit Handbook for details.

Inpatient Acute Hospital Services (including day surgery)

All covered services including the following:

- Coronary care
- Hospital services
- Intensive care
- Physicians' and surgeons' services including consultations
- Semi-private room and board

Subject to hospital inpatient copayment+.

Hospital Outpatient Department Services

- Anesthesia services
- Endoscopic procedures
- Laboratory tests and x-rays
- Physicians' and surgeons' services
- Chemotherapy/Radiation therapy

Covered in full

Physician services (including covered services by a podiatrist)

- Chemotherapy
- Changes and removals of casts, dressings, or sutures
- Health education including nutritional counseling
- Preventive care including routine physical examinations, immunizations, annual eye examinations, school, camp, sports, and premarital examinations
- Vision and hearing screenings
- Administration of injections/Allergy tests and treatments
- Diagnostic screening and tests, including but not limited to mammograms, blood tests and screenings mandated by state law
- Sick and well office visits, including psychopharmacological services

$15 copayment per visit. (Please note: diagnostic tests, mammograms, x-rays, and immunizations will be covered in full if billed without an office visit and no other services are provided.)

- Administration of allergy injections

$5 copayment per visit.

Maternity Services

- Prenatal and postpartum care
- All hospital services for mother and routine nursery charges for newborn

Subject to hospital inpatient copayment+.

Mental Health and Drug and Alcohol Rehabilitation Services

Please note that no day or visit limits apply to inpatient or outpatient mental health treatment for biologically-based mental disorders, rape-related mental or emotional disorders, and non-biologically-based mental, behavioral or emotional disorders for children and adolescents. No day or visit limits apply to inpatient or outpatient drug and alcohol rehabilitation services that are authorized by an HPHC mental health clinician in conjunction with treatment of mental disorders. (Please see your Benefit Handbook for details.)

- Outpatient mental health services

Covered up to 24 visits per calendar year for individual therapy and 25 visits per calendar year for group therapy with a combined maximum not to exceed 25 individual and group therapy visits per calendar year. $15 copayment per visit for individual therapy visits 1-24. $10 copayment per visit for group therapy visits 1-25.

- Outpatient drug and alcohol rehabilitation services

Covered up to 20 visits or $500 in benefit value, whichever is greater. $15 copayment per visit for individual therapy visits 1-8. $25 copayment per visit for individual therapy visits after 8. $10 copayment per visit for group therapy visits.

- Psychological testing

$15 copayment per visit.

- Inpatient mental health services

Subject to hospital inpatient copayment+ in a licensed general hospital.
*Subject to hospital inpatient copayment+, up to 60 days per member per calendar year in a psychiatric hospital.**

- Inpatient drug and alcohol rehabilitation services

*Subject to hospital inpatient copayment+, up to 30 days per member per calendar year.**

- Detoxification

Subject to hospital inpatient copayment+ for inpatient services. $15 copayment per visit for outpatient services.

**Note: Partial hospitalization services are available up to a maximum of 120 days per calendar year in place of inpatient mental health services. Partial hospitalization services are available up to a maximum of 60 days per calendar year in place of inpatient drug and alcohol rehabilitation services.*

Home Health Care Services

- Home care services
- Intermittent skilled nursing care

Covered in full

Dental Services

- Preventive care for children under the age of 14. Two visits per member per calendar year including examination, cleaning, x-rays and fluoride treatment.

Covered in full

- Initial emergency treatment (within 72 hours of injury) necessary to repair oral injuries including x-rays, surgical procedures, extractions, and suturing
- Extraction of impacted teeth

The applicable copayment will be determined by location of service.

Emergency Services

- You are always covered for care in a Medical Emergency. A referral from your PCP is not needed. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. If you are hospitalized, you must call your PCP within 48 hours, or as soon as you can. Please note that this requirement is met if your attending physician has already given notice to your PCP.

$50 copayment per visit in the emergency room or a $15 copayment per visit in a doctor's office or hospital outpatient department. This copayment is waived if admitted directly to the hospital from the emergency room.

Skilled Nursing Care and Inpatient Rehabilitation

- Room and board, special services and physicians' services

100 days per calendar year at a semi-private rate for each benefit, subject to hospital inpatient copayment.+

Other Health Services

- Ambulance services
- Low protein foods ($2,500 per member per calendar year)
- State mandated formulas
- Lead testing

Covered in full

- Vision Hardware for special conditions

Covered in full up to the applicable benefit limits as described in the Benefit Handbook.

- Cardiac rehabilitation
- Dialysis
- Family planning services/Infertility services
- Medical treatment of temporomandibular joint dysfunction (TMJ)
- Speech-language and hearing services including therapy
- Physical and occupational therapies - up to 90 consecutive days per condition
- House calls by a physician

$15 copayment per visit.

- Hospice services
- Human organ transplants
- Cosmetic surgery as described in the Benefit Handbook

The applicable copayment will be determined by location of service.

- Durable medical and prosthetic equipment (including ostomy supplies)

Covered in full after a copayment of 20% of the equipment cost to HPHC, not to exceed a Member's total expense of $1,000. There is no coverage after $5,000 in equipment costs have been paid, including Member copayments. Included in this benefit is coverage for wigs, up to $350 per member per calendar year when needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury.

- Diabetes equipment and supplies

Molded shoes and inserts; dosage gauges; injectors; lancet devices; voice synthesizers and visual magnifying aids are subject to the applicable copayment under the durable medical and prosthetic equipment benefit.
Blood glucose monitors, insulin pumps and infusion devices are covered in full.
Insulin; insulin syringes; insulin pump supplies; insulin pens with insulin; lancets; oral agents for controlling blood sugar; blood test strips; and glucose, ketone and urine test strips are covered in full after the applicable prescription drug copayment listed on your ID card, if your Employer Group has selected prescription drug coverage. If prescription drug coverage is not available, then you will pay a $5 copayment for Generic items, a $10 copayment for Select Brand items and a $25 copayment for Non-Select Brand items.

- Early intervention services

$15 copayment per visit up to a maximum of $3,200 per member per calendar year and a lifetime maximum of $9,600.

Special Enrollment Rights

If an employee declines enrollment for the employee and his or her dependents (including his or her spouse) because of other health insurance coverage, the employee may be able to enroll in this plan in the future along with his or her dependents, provided that enrollment is requested within 30 days after other coverage ends. In addition, if the employee has a new dependent as a result of marriage, birth, adoption or placement for adoption, the employee may be able to enroll along with his or her dependents, provided that enrollment is requested within 30 days after the marriage, birth, adoption or placement for adoption.

Membership Requirements

There are a few requirements that you must meet in order to be covered by the plan. (Please see your Benefit Handbook for a complete description).

- Members must live in the Plan's Enrollment Area for at least nine months of the year. An exception is made for full-time student dependents and dependents enrolled under a Qualified Medical Support Order.
- All your medical and health care needs must be provided or arranged by your primary care physician (PCP), except in a medical emergency, when you are temporarily outside the Plan Service Area, or when you need one of the special services which do not require a referral. The Plan Service Area is the state in which you live.

Annual Out-of-Pocket Maximums

- The total maximum copayments you will be required to pay for all covered services excluding riders (e.g. prescription drugs, adult preventive dental and vision hardware) shall not exceed $2,000 per Member per calendar year or a total of $4,000 per Family per calendar year. The Plan will notify you if you reach these limits. If you feel that you reached these limits, but have not been notified, please contact the Plan.

+ Inpatient Copayment

- Hospital Inpatient Copayment: $150 per admission up to an aggregate maximum of $300 per contract per calendar year. Day Surgery is covered in full.

Exclusions

The Plan does not provide coverage for:

- services not approved, arranged, or provided by your PCP
- cosmetic procedures
- commercial diet plans or weight loss programs
- transsexual surgery, including related procedures
- procedures which are experimental or unproven
- eyeglasses, contact lenses, and fittings, unless your Employer Group has purchased the Vision Rider
- refractive eye surgery
- transportation other than by ambulance
- costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities
- costs for services covered by workers' compensation, third party liability, other insurance coverage, or an employer under state or federal law
- blood and blood products
- educational services (including problems of school performance) or testing for developmental, educational, or behavioral problems
- sensory integrative praxis tests
- physical examinations for insurance, licensing, or employment
- vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation
- rest or custodial care
- personal comfort or convenience items
- non-durable medical equipment, unless used as a part of the treatment at a medical facility or as part of approved home health care services
- reversal of voluntary sterilization (including procedures necessary for conception as a result of voluntary sterilization) and any form of surrogacy
- infertility treatment for Members who are not medically infertile
- delivery outside the service area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery
- special equipment needed for sports or occupational purposes
- services for which no charge would be made in the absence of insurance
- services for non-Members
- services after the termination of membership
- services or supplies given to you by 1) anyone related to you by blood, marriage, or adoption, or, 2) anyone who ordinarily lives with you
- services that are not medically necessary
- services for which no coverage is provided in the Benefit Handbook, Schedule of Benefits, or Prescription Drug Brochure
- hearing aids
- foot orthotics, except as required by law
- dental services including periodontal, restorative, and orthodontic services
- chiropractic care
- osteopathic manipulation, routine foot care, biofeedback, pain management programs, massage therapy, acupuncture, and sports medicine clinics
- hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy

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OOA VALUE

TUFTS Health Plan

SUMMARY OF BENEFITS

Effective December 1, 2003

Outpatient Medical Care	Unauthorized Benefits Only
Doctor's Office Visits	$15 per visit
Routine Physical Exams	$15 per visit
Well-Child Care	$15 per visit
Specialist Care, Consultations	$15 per visit
OB/GYN visits	$15 per visit
Prenatal and Postnatal Care	$15 per visit
Laboratory Tests, including Pap Smear	Covered in Full
Diagnostic X-rays, including Mammograms	Covered in Full
Injections and Immunizations	Covered in Full
X-ray Therapy	Covered in Full
Speech Therapay and Short-term Physical/Occupational Therapy	$15 per visit
Annual Routine Eye Exams	$15 per visit
Spinal Manipulation (12 visits per calendar year)	$15 per visit

Inpatient Hospital Care and Surgery*	
Day Surgery	$0 per surgery
Acute care for Illness or Injury, and Maternity Services	$150 per admission
Physician's Care while hospitalized	Covered in Full
Surgery and Surgeon's Services while hospitalized	Covered in Full
Newborn Care in hospital	Covered in Full
Anesthesia while hospitalized	Covered in Full
Medications while hospitalized	Covered in Full
Nursing Care while hospitalized	Covered in Full
X-ray and Lab Services while hospitalized	Covered in Full
Intensive Care/Coronary Care while hospitalized	Covered in Full
Radiation Therapy while hospitalized	Covered in Full
Skilled Nursing In Skilled Nursing Facility (up to 100 days per calendar year)	Covered in Full

Wellness Programs	
Membership at Network Fitness Facilities	Multiple discount options
Weight Watchers Weight Management Program	Discounted membership
Health Education (may require advance payment)	30% discount per program

* Semi-private room, unless private room is medically necessary.

(OVER)

Value EPO C

Mental Health*	
Outpatient Care (up to 24 visits per calendar year)	$15 per visit
Inpatient Care (Services provided through a Designated Facility Program for up to 60 days per calendar year)	$150 per admission

Substance Abuse**	
Outpatient Care (Alcohol, Drug and Detoxification) (Covered up to $500 per calendar year)	$15 per visit
Inpatient Care (Services provided through a Designated Facility Program for up to 30 days per calendar year)	$150 per admission

Emergency Care	
In Doctor's Office	$15 per visit
In Emergency Room	$50 per visit

Other Services	
Durable Medical Equipment ($5,000 calendar year maximum)	Plan pays 80%; Member pays 20%
Ambulance (when medically necessary)	Covered in Full

Inpatient Out-of-Pocket Maximum	
Annual Indivicual Out-of-Pocket Maximum	$300
Annual Family Out-of-Pocket Maximum***	$300

* As required by law, coverage for certain mental health disorders is the same as for other medical conditions. See your member benefit document for more information.

** Treatment for detoxification is not subject to substance abuse day and visit limits listed in this document. See your member benefit document for more information.

*** No more than two inpatient copayments will apply to each family. Maximums will be administered by City of Newton.

There are some services that the plan does not cover. These include, but are not limited to: A service or supply not described as covered in the member's benefit document • Exams required by a third party, such as your employer, an insurance company, school or court • Any tax, surcharge, assessment or other similar fee imposed under any state or federal law or regulation on any provider, member, service, supply or medication • Cosmetic surgery or any other cosmetic procedure except certain reconstructive procedures • Experimental or investigational drugs, services and procedures • Eyeglasses or contact lenses • Whole blood, packed red blood cells and blood donor fees • Drugs for use outside of hospital except as covered under Prescription Drug Coverage • Personal comfort items • Custodial care • A service furnished to someone other than the member • Routine foot care • Charges incurred for stays in a covered facility beyond the discharge hour • Care for conditions that state or local law requires to be treated in public facility • Medical or surgical procedures for sexual reassignment and reversal of voluntary sterilization • Long-term (more than 60 days) outpatient physical and occupational therapy services • Foot orthotics • Assisted reproductive technology (e.g. IVF) procedures for non-Massachusetts residents

This is a summary only. Please refer to your member benefit document for more detailed information. Copies are available through your employer.

Administered by Total Health Plan, Inc., A Tufts Health Plan company.

Value EPO C

POS VALUE SUMMARY OF BENEFITS

TUFTS Health Plan
No one does more to keep you healthy.

Tufts Health Plan's point-of-service (POS) plan covers preventive and medically necessary health care services and supplies.

As a POS member, you can choose between two levels of coverage:

- **Coverage at the authorized level of benefits, a higher level of coverage,** when care is provided or authorized by your primary care physician (PCP) in the Tufts Health Plan network. You pay a copayment at the time you receive covered health care services.
- **Coverage at the unauthorized level of benefits,** when covered health care services are not provided or authorized by your Tufts Health Plan PCP. You pay a deductible and coinsurance when you obtain care at the unauthorized level of benefits.
  - **A deductible** is the amount you must pay out of pocket before any coverage is available at the unauthorized level of benefits.
  - Once you have paid the deductible, you pay **coinsurance--**a percentage of the covered medical costs you are responsible for paying at the unauthorized level of benefits--until you reach the **out-of-pocket maximum.**
  - Once you reach the out-of-pocket maximum, you are covered in full up to the reasonable charge for most out-of-network covered services for the remainder of the plan (usually a plan year).
  - To be reimbursed for covered services at the unauthorized level of benefits, you may need to submit a claim form. You may be responsible for paying any difference between what the plan covers and what the out-of-network provider charges for a service.
- Emergency care is covered at the authorized level of benefits, regardless of whether you see an in-network or out-of-network provider.

The deductible and out-of-pocket maximum for this plan are listed on this benefit summary.

✓ This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance.

Prescription Drug Coverage	For up to a 30-day supply at a participating retail pharmacy	For up to a 90-day supply through our mail order service
Tier 1	$5	$10
Tier 2	$20	$40
Tier 3	$30	$60

Deductible and Out-of-pocket Maximums (per plan year)	Individual	Family
Deductible (applies to unauthorized care only)	$250	$500
Out-of-pocket maximum (includes deductible and coinsurance)	$1,000	$15,000
Inpatient copayment maximum (No more than two inpatient copayments will apply to each family. Maximums will be administered by the City of Newton)	$300	$300

Outpatient Medical Care (No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams, or mammograms)	Authorized	Unauthorized (after deductible)
Most Provider Office Visits	$15 per visit	Plan covers 80%
Routine Physical Exams (including most preventive screenings)	$15 per visit	Plan covers 80%
Well-Child Care	$15 per visit	Plan covers 80%
OB/GYN Visits	$15 per visit	Plan covers 80%
Outpatient Maternity Care (This office visit copayment will apply per visit up to 10 visits per pregnancy. After 10 visits, these services are covered in full for the remainder of your pregnancy.)	$15 per visit	Plan covers 80%
Routine Eye Exams (1 visit every 12 months)	$15 per visit	Plan covers 80%
Nutritional Counseling (When medically necessary)	$15 per visit	Plan covers 80%
Preventive Immunizations	Covered in full	Plan covers 80%
Preventive Pap Smears and Mammograms	Covered in full	Plan covers 80%
Non-preventive Immunizations	Covered in full	Plan covers 80%
Non-routine Pap Smears and Mammograms	Covered in full	Plan covers 80%
Allergy Injections	Copay may apply	Plan covers 80%
Diagnostic Procedures	Covered in full	Plan covers 80%
Diagnostic Imaging - General Imaging (such as X-rays and ultrasounds)	Covered in full	Plan covers 80%
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)	Covered in full	Plan covers 80%
Diagnostic Lab Tests	Covered in full	Plan covers 80%
Speech and Short-term Physical/Occupational Therapy	$15 per visit	Plan covers 80%
Spinal Manipulation (12 visits per plan year)	$15 per visit	Plan covers 80%
Day Surgery	Covered in full	Plan covers 80%

Inpatient Hospital Care (Semi-private room, unless private room is medically necessary)	Authorized	Unauthorized (after deductible)
All Hospital Services (Acute Care) and Maternity Care	$150 per admission	Plan covers 80%
Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year)	Covered in full	Plan covers 80%
Emergency Care		
In Doctor's Office	$15 per visit	
In Emergency Room	$50 per visit	
Mental Health*	Authorized	Unauthorized (after deductible)
Outpatient Care (up to 30 visits per plan year)	$15 per visit	Plan covers 80%
Inpatient Care (Services provided at a designated facility for up to 60 days per plan year)	**Error! Not a valid link.** per admission	Plan covers 80%
Substance Abuse**	Authorized	Unauthorized (after deductible)
Outpatient Care (Alcohol and drug treatment, detoxification) (Up to $500 per plan year for treatment)	$15 per visit	Plan covers 80%
Inpatient Care (Services provided at a designated facility for up to 30 days per plan year)	**Error! Not a valid link.** per admission	Plan covers 80%
Other Health Services	Authorized	Unauthorized (after deductible)
Durable Medical Equipment	Covered in full	Plan covers 80%
Ambulance Service	Covered in full	Plan covers 80%
Hospice Care	Covered in full	Plan covers 80%
Home Health Care	Covered in full	Plan covers 80%
Pediatric Dental: X-Rays (full mouth) once every 5 years. Bitewings, once every 6 months and periapicals as needed. Periodic oral exam, oral prophylaxis and fluoride treatment once every 6 months.	Covered for children under 12	Not covered

Great Savings While You Get Healthy

In addition to your covered benefits, we offer great savings on a wide variety of healthy products, services, and treatments—from acupuncture and massage therapy to wellness programs. You save while you're taking care of your health. That's a real win-win! To learn more, visit www.tuftshealthplan.com and click on Discounts on the Members tab.

Regular exercise is an important part of living a healthy lifestyle, and we want to do whatever we can to help you and your family incorporate activity into your daily lives. That's why **your Tufts Health Plan membership includes a $150 rebate per household toward your health and fitness club fees.** See the fitness reimbursement flyer in your member enrollment kit for more information.

*Outpatient and inpatient mental health services are treated the same as any other medical condition when provided as required by law for the following: biologically-based mental disorders; certain mental, behavioral or emotional disorders for children under age 19; and rape-related mental or emotional disorders. See your Tufts Health Plan member benefit document for more information.

**Outpatient and inpatient substance abuse services are treated the same as mental health conditions when provided in conjunction with treatment of a mental disorder. Treatment for detoxification is not subject to substance abuse day and dollar limits listed in this document. See your Tufts Health Plan member benefit document for more information.

There are some services that the plan does not cover. These include, but are not limited to: A service or supply not described as a covered service in your Tufts Health Plan member benefit document • Exams required by a third party, such as your employer, an insurance company, school, or court • Cosmetic surgery or any other cosmetic procedure, except certain reconstructive procedures described in your Tufts Health Plan member benefit document • Experimental or investigational drugs, services, and procedures • Eyeglasses or contact lenses, except as described in your Tufts Health Plan member benefit document • Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, or blood products, except as described in your Tufts Health Plan member benefit document • Drugs for use outside of hospital, except as covered under Prescription Drug Coverage • Personal comfort items • Custodial care • A service furnished to someone other than the member • Routine foot care, except as described in your Tufts Health Plan member benefit document • Charges incurred for stays in a covered facility beyond the discharge hour • Care for conditions that state or local law requires to be treated in a public facility • Medical or surgical procedures for sexual reassignment and reversal of voluntary sterilization • Foot orthotics, except therapeutic/molded shoes for an individual with severe diabetic foot disease • Assisted reproductive technology (e.g. IVF) procedures for non-Massachusetts residents • Spinal manipulation services for members age 12 and under • Except for Emergency care, a service, supply or medication that is obtained outside of the 50 United States • Private duty nursing (block or non-intermittent nursing) • Hearing aids.

This is a summary only. Please refer to the member benefit document for a detailed explanation of your coverage. If there is a difference between the information in this benefit summary and your member benefit document, the terms of your member benefit document will govern. If you have additional questions, please call a member services specialist at 1-800-462-0224.

Offered by Tufts Associated Health Maintenance Organization, Inc. or Total Health Plan, Inc., both Tufts Health Plan companies.

Massachusetts Requirement to Purchase Health Insurance: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector Web site (www.mahealthconnector.org). This health plan meets Minimum Creditable Coverage standards that are effective January 1, 2009 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards. This disclosure is for minimum creditable coverage standards that are effective January 1, 2009. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards. If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its Web site at www.mass.gov/doi

EPO VALUE
SUMMARY OF BENEFITS

TUFTS Health Plan
No one does more to keep you healthy.

With Tufts Health Plan's EPO (exclusive provider option) plan, you enjoy comprehensive coverage for your health care needs, while your out-of-pocket costs are kept to a minimum.

In general, preventive and medically necessary health care services and supplies are covered when they are provided or authorized by your network primary care physician (PCP).

As an EPO member:

- You must choose a PCP from the Tufts Health Plan network of providers.
- In most cases, your PCP must provide or authorize (provide a referral for) your care.
- You pay the applicable copayment at the time you receive covered health care services. There are annual maximums on the number or amount of copayments you pay for day surgery and inpatient care. Please check this benefit summary for more information.

EPO members do not need a PCP referral for certain types of covered services, including:

- Maternity care and medically necessary evaluations and related health care services for acute/emergency gynecologic conditions, when the services are provided by an obstetrician, gynecologist, certified nurse midwife, or family practitioner in the Tufts Health Plan network
- Routine gynecologic exams and any medically necessary OB/GYN follow-up care resulting from that exam, when obtained from a provider in the Tufts Health Plan network
- Emergency care in an emergency room or a physician's office
- Mammography screening, when obtained from a provider in the Tufts Health Plan network
- One routine eye exam every 12 months, when provided by a network physician, if your plan offers this benefit

ATTACHMENT - E

✓ This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance.

Prescription Drug Coverage	For up to a 30-day supply at a participating retail pharmacy	For up to a 90-day supply through our mail order service
Tier 1	$5	$10
Tier 2	$20	$40
Tier 3	$30	$60

Out-of-Pocket Maximums (per plan year)	Individual	Family
Inpatient copayment maximum (No more than two inpatient copayments will apply to each family. Maximums will be administered by the City of Newton)	$300	$300

Outpatient Medical Care (No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams, or mammograms)	
Most Provider Office Visits	$15 per visit
Routine Physical Exams (including most preventive screenings)	$15 per visit
Well-Child Care	$15 per visit
OB/GYN Visits	$15 per visit
Outpatient Maternity Care (This office visit copayment will apply per visit up to 10 visits per pregnancy. After 10 visits, these services are covered in full for the remainder of your pregnancy.)	$15 per visit
Routine Eye Exams (1 visit every 12 months)	$15 per visit
Nutritional Counseling (When medically necessary)	$15 per visit
Preventive Immunizations	Covered in full
Preventive Pap Smears and Mammograms	Covered in full
Non-preventive Immunizations	Covered in full
Non-routine Pap Smears and Mammograms	Covered in full
Allergy Injections	Copay may apply
Diagnostic Procedures	Covered in full
Diagnostic Imaging - General Imaging (such as X-rays and ultrasounds)	Covered in full
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)	Covered in full
Diagnostic Lab Tests	Covered in full
Speech and Short-term Physical/Occupational Therapy	$15 per visit
Spinal Manipulation (12 visits per plan year)	$15 per visit
Day Surgery	Covered in full
Inpatient Hospital Care (Semi-private room, unless private room is medically necessary)	
All Hospital Services (Acute Care) and Maternity Care	$250 per admission
Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year)	Covered in full
Emergency Care	
In Doctor's Office	$15 per visit
In Emergency Room	$50 per visit
Mental Health*	
Outpatient Care (up to 30 visits per plan year)	$15 per visit
Inpatient Care (Services provided at a designated facility for up to 60 days per plan year)	$150 per admission
Substance Abuse**	
Outpatient Care (Alcohol and drug treatment, detoxification) (Up to $500 per plan year for treatment)	$15 per visit
Inpatient Care (Services provided at a designated facility for up to 30 days per plan year)	**Error! Not a valid link.** per admission
Other Health Services	
Durable Medical Equipment	Covered in full
Ambulance Service	Covered in full
Hospice Care	Covered in full
Home Health Care	Covered in full
Pediatric Dental: X-Rays (full mouth) once every 5 years. Bitewings, once every 6 months	Covered for

and periapicals as needed. Periodic oral exam, oral prophylaxis and fluoride treatment once every 6 months.	children under 12

Great Savings While You Get Healthy

In addition to your covered benefits, we offer great savings on a wide variety of healthy products, services, and treatments—from acupuncture and massage therapy to wellness programs. You save while you're taking care of your health. That's a real win-win! To learn more, visit www.tuftshealthplan.com and click on Discounts on the Members tab.

Regular exercise is an important part of living a healthy lifestyle, and we want to do whatever we can to help you and your family incorporate activity into your daily lives. That's why **your Tufts Health Plan membership includes a $150 rebate per household toward your health and fitness club fees.** See the fitness reimbursement flyer in your member enrollment kit for more information.

*Outpatient and inpatient mental health services are treated the same as any other medical condition when provided as required by law for the following: biologically-based mental disorders; certain mental, behavioral or emotional disorders for children under age 19; and rape-related mental or emotional disorders. See your Tufts Health Plan member benefit document for more information.

**Outpatient and inpatient substance abuse services are treated the same as mental health conditions when provided in conjunction with treatment of a mental disorder. Treatment for detoxification is not subject to substance abuse day and dollar limits listed in this document. See your Tufts Health Plan member benefit document for more information.

There are some services that the plan does not cover. These include, but are not limited to: A service or supply not described as a covered service in your Tufts Health Plan member benefit document • Exams required by a third party, such as your employer, an insurance company, school, or court • Cosmetic surgery or any other cosmetic procedure, except certain reconstructive procedures described in your Tufts Health Plan member benefit document • Experimental or investigational drugs, services, and procedures • Eyeglasses or contact lenses, except as described in your Tufts Health Plan member benefit document • Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, or blood products, except as described in your Tufts Health Plan member benefit document • Drugs for use outside of hospital, except as covered under Prescription Drug Coverage • Personal comfort items • Custodial care • A service furnished to someone other than the member • Routine foot care, except as described in your Tufts Health Plan member benefit document • Charges incurred for stays in a covered facility beyond the discharge hour • Care for conditions that state or local law requires to be treated in a public facility • Medical or surgical procedures for sexual reassignment and reversal of voluntary sterilization • Foot orthotics, except therapeutic/molded shoes for an individual with severe diabetic foot disease • Assisted reproductive technology (e.g. IVF) procedures for non-Massachusetts residents • Spinal manipulation services for members age 12 and under • Except for Emergency care, a service, supply or medication that is obtained outside of the 50 United States • Private duty nursing (block or non-intermittent nursing) • Hearing aids.

This is a summary only. Please refer to the member benefit document for a detailed explanation of your coverage. If there is a difference between the information in this benefit summary and your member benefit document, the terms of your member benefit document will govern. If you have additional questions, please call a member services specialist at 1-800-462-0224.

Offered by Total Health Plan, Inc., a Tufts Health Plan company.

Massachusetts Requirement to Purchase Health Insurance: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector Web site (www.mahealthconnector.org). This health plan meets Minimum Creditable Coverage standards that are effective January 1, 2009 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards. This disclosure is for minimum creditable coverage standards that are effective January 1, 2009. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards. If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its Web site at www.mass.gov/doi.

MA-1/11 Rev. 8/10

ADVANTAGE EPO
SUMMARY OF BENEFITS

With Tufts Health Plan Advantage EPO, health care services may be covered subject to the plan's deductible, covered with a copayment, or covered in full. The deductible is the amount you must first pay out of pocket before many services are covered. The deductible is calculated each Plan year. Once you meet the deductible, the plan covers in full services that are subject to the deductible for the remainder of the Plan year.
In addition, Advantage EPO is compatible with health reimbursement arrangements (HRAs), which are designed specifically to help with an individual's health care expenses.

As an Advantage EPO member:

• You must choose a primary care provider (PCP) from the Tufts Health Plan network of providers.
• In most cases, your network PCP must provide or authorize (provide a referral for) your care.
• You do not need a referral for emergency care.

How services are covered with Advantage EPO

In general, the Advantage EPO plan covers preventive and medically necessary health care services and supplies when they are provided or authorized by your network PCP. Services may be:

• **Covered subject to the plan's deductible:** Certain covered services—usually those used to diagnose, treat, or monitor health conditions (for example, an MRI)—are subject to the plan's deductible. Note: Services subject to the plan's deductible may also be performed during or in conjunction with preventive services (for example, during an office visit). The individual and family deductibles for this plan are listed below.
• **Covered in full or with a copayment:** You pay the applicable copayment at the time you receive covered health care services. With this plan, preventive services are covered in full and are not subject to the deductible. Generally, preventive services are the services your provider provides to help you stay healthy. Preventive services are needed at all ages. They might be office visits for routine physicals for children and adults, tests (also called screenings) to evaluate your general health or the health of certain parts of your body, measurements, immunizations (or shots) for children and adults, certain advice about health, or special tests at certain times in your life.

Out-of-pocket Maximum: Your deductible and copayments accumulate toward your out-of-pocket maximum. Once you reach your out-of-pocket maximum, you are covered in full for services subject to deductible and copayments. Pharmacy copayments are excluded from the out-of-pocket maximum. Please note that this is a summary of benefits only. For more detailed benefit information, please refer to this plan's member benefit document.

This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance.

Prescription Drug Coverage **For up to a 30-day supply at a participating retail pharmacy**
For up to a 90-day supply through our mail order service

Tier 1 $15 $30
Tier 2 $30 $60
Tier 3 $50 $100
Note: there is a 30-day supply limit when filling prescriptions at a retail pharmacy

Deductible and Out-of-Pocket Maximums (per Plan year) Individual Family

Deductible $250 $500
Out-of-pocket Maximum (includes deductible and copayments) $1,000 $2,500

Outpatient Medical Care (No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams, or mammograms)

PCP Specialist

Routine Physical Exams (including most preventive screenings. Please note: some services performed during a routine office visit may be subject to your deductible.) Covered in full
Non-routine Office Visits (including PCP and specialist consultations) $20 per visit $35 per visit
Preventive Immunizations Covered in full
Non-preventive Immunizations Covered in full after deductible
Preventive Pap Smears and Mammograms Covered in full
Non-preventive Pap Smears and Mammograms Covered in full after deductible
Colonoscopy (without surgical intervention) Covered in full
Colonoscopy (with surgical intervention) Covered in full after deductible
Outpatient Maternity Care (This office visit copayment will apply per visit up to 10 visits per pregnancy. After 10 visits, these services are covered in full for the remainder of your pregnancy.)
$20 per visit $20 per visit
OB/GYN Visits $20 per visit $20 per visit
Well-Child Care Covered in full
Routine eye exams with an EyeMed Vision Care provider (1 visit every 12 months) Covered in full
Nutritional Counseling (When medically necessary) $20 per visit $35 per visit
Allergy Injections Covered in full after deductible
Speech Therapy (no visit limit); Short-term Physical Therapy (30 visits per Plan year); Covered in full after deductible

Short-term Occupational Therapy (30 visits per Plan year)
Spinal Manipulation (12 visits per Plan year) Covered in full after deductible
Diagnostic Procedures Covered in full after deductible
Diagnostic Imaging - General Imaging (such as X-rays and ultrasounds) Covered in full after deductible
Diagnostic Imaging - High-Tech Imaging
(MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology) Covered in full after deductible
Diagnostic Lab Tests Covered in full after deductible
Day Surgery Covered in full after deductible

Inpatient Hospital Care (Semi-private room, unless private room is medically necessary)

All Hospital Services (Acute Care) and Maternity Care Covered in full after deductible
Skilled Nursing in Skilled Nursing Facility (up to 100 days per Plan year) Covered in full after deductible

Emergency Care PCP Specialist

In Provider's Office $20 per visit $35 per visit
In Emergency Room $100 per visit

Mental Health

Outpatient Care $20 per visit
Inpatient Care (Services provided at a designated facility) Covered in full after deductible

Substance Abuse

Outpatient Care (Alcohol and drug treatment, detoxification) $20 per visit
Inpatient Care (Services provided at a designated facility) Covered in full after deductible

Other Health Services

Durable Medical Equipment Covered in full
Ambulance Service Covered in full after deductible
Hospice Care Covered in full after deductible
Home Health Care Covered in full after deductible

Great Savings While You Get Healthy

We want to help you and your family incorporate activity into your daily lives. That’s why your Tufts Health Plan
membership includes a **$150 rebate** per subscriber household toward your fees for a qualified health and

fitness club.

There are some services that the plan does not cover. These include, but are not limited to: A service or supply not described as a covered service in your Tufts Health Plan member benefit document • Exams required by a third party, such as your employer, an insurance company, school, or court • Cosmetic surgery or any other cosmetic procedure, except certain reconstructive procedures described in your Tufts Health Plan member benefit document • Experimental or investigational drugs, services, and procedures • Eyeglasses or contact lenses, except as described in your Tufts Health Plan member benefit document • Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, or blood products, except as described in your Tufts Health Plan member benefit document • Drugs for use outside of a hospital, except as described in your Tufts Health Plan member benefit document • Personal comfort items • Custodial care • A service furnished to someone other than the member • Routine foot care, except as described in your Tufts Health Plan member benefit document • Charges incurred for stays in a covered facility beyond the discharge hour • Care for conditions that state or local law requires to be treated in a public facility • Medical or surgical procedures for sexual reassignment and reversal of voluntary sterilization • Foot orthotics, except therapeutic/molded shoes for an individual with severe diabetic foot disease • Assisted reproductive technology (e.g. IVF) procedures for non-Massachusetts residents • Spinal manipulation services for members age 12 and under • Except for Emergency care or Urgent care while traveling, a service, supply or medication that is obtained outside of the 50 United States • Private duty nursing (block or non-intermittent nursing) • Hearing aids.

This is a summary only. Please refer to the member benefit document for a detailed explanation of your coverage. If there is a difference between the information in this benefit summary and your member benefit document, the terms of your member benefit document will govern. If you have additional questions, please call a Member Specialist at 1-800-462-0224.

Offered by Tufts Associated Health Maintenance Organization, Inc.

Massachusetts Requirement to Purchase Health Insurance: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector Web site (www.mahealthconnector.org). This health plan meets Minimum Creditable Coverage standards that are effective January 1, 2009 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards. This disclosure is for minimum creditable coverage standards that are effective January 1, 2009. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards. If you have **questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its Web site at www.mass.gov/doi.**

MA-1/11 Rev. 8/10

ADVANTAGE PPO
SUMMARY OF BENEFITS

With Tufts Health Plan Advantage PPO, most health care services are covered subject to the plan's deductible or coinsurance, covered with a copayment, or covered in full. Services are covered at two levels of benefits: the in-network level of benefits and the out-of-network level of benefits.

As an Advantage PPO member:

- You can seek covered health care services from most licensed providers in or out of the Tufts Health Plan network.
- No referrals are needed.
- You do not have to choose a primary care provider (PCP).

How services are covered with Advantage PPO

In general, Advantage PPO covers preventive and medically necessary health care services and supplies in the following ways:

- **Coverage at the in-network level of benefits:** When you receive care from a provider in the Tufts Health Plan network, services may be covered subject to the plan's deductible or coinsurance, covered with a copayment, or covered in full.
- **Covered subject to the plan's deductible:** Certain covered services—usually those used to diagnose, treat, or monitor health conditions (for example, an MRI)—are subject to the plan's deductible. The deductible is the amount you must first pay out of pocket each plan year before many services are covered. Once you meet the deductible, those services are covered in full for the remainder of the plan year. Note: Services subject to the plan's deductible may also be performed during or in conjunction with preventive services; for example, during an office visit.
- **Covered in full or with a copayment:** You pay the applicable copayment at the time you receive covered health care services. With this plan, preventive services are covered in full and are not subject to the plan's deductible. Generally, preventive services are the services your provider provides to help you stay healthy. Preventive services are needed at all ages. They might be office visits for routine physicals for children and adults, tests (also called screenings) to evaluate your general health or the health of certain parts of your body, measurements, preventive immunizations (or shots) for children and adults, certain advice about health, or special tests at certain times in your life.
- **Covered subject to coinsurance:** Coinsurance is a percentage of the covered medical costs you are responsible for paying. You pay coinsurance on durable medical equipment until you reach the plan's out-of-pocket maximum, after which you are covered in full.
- **Coverage at the out-of-network level of benefits:** When you receive care from a provider who is not in the Tufts Health Plan network, services will be covered subject to the plan's deductible and then coinsurance. When you receive covered out-of-network services, you pay coinsurance until you reach the plan's out-ofpocket maximum, after which you are covered in full up to the reasonable charge for covered services for the remainder of the plan year. You may also be responsible for paying any difference between what the plan covers and what an out-of-network provider charges for a service.

The individual and family deductibles and out-of-pocket maximums for this plan are listed in this benefit summary. Please note that this is a summary of benefits only. For more detailed benefit information, please refer to this plan's member benefit document.

This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance.

Prescription Drug Coverage
For up to a 30-day supply at a participating retail pharmacy

For up to a 90-day supply
through our mail order service
Tier 1 $15 $30
Tier 2 $30 $60
Tier 3 $50 $100
Note: there is a 30-day supply limit when filling prescriptions at a retail pharmacy
Deductible and Out-of-Pocket Maximums (per plan year) Individual Family
Deductible $250 $500
Out-of-pocket Maximum (includes deductible, coinsurance, and copayments) $1,000 $2,500
In-Network
Outpatient Medical Care
PCP Specialist
Out-of-Network
(after deductible)
Routine Physical Exams (including most preventive screenings. Please note: some services performed during a routine office visit may be subject to your deductible.)
Covered in full Plan covers 80%
Non-routine Office Visits (including PCP and specialist consultations) $20 per visit $35 per visit Plan covers 80%
Preventive Immunizations Covered in full Plan covers 80%
Non-preventive Immunizations Covered in full after deductible Plan covers 80%
Preventive Pap Smears and Mammograms Covered in full Plan covers 80%
Non-preventive Pap Smears and Mammograms Covered in full after deductible Plan covers 80%
Colonoscopy (without surgical intervention) Covered in full Plan covers 80%
Colonoscopy (with surgical intervention) Covered in full after deductible Plan covers 80%
Outpatient Maternity Care (This office visit copayment will apply per visit up to 10 visits per pregnancy. After 10 visits, these services are covered in full for the remainder of your pregnancy.)
$20 per visit $20 per visit Plan covers 80%
OB/GYN Visits $20 per visit $20 per visit Plan covers 80%
Well-Child Care Covered in full Plan covers 80%
Routine eye exams (1 visit every 12 months)—you must use an EyeMed Vision Care provider to be covered at the in-network level of benefits
Covered in full Plan covers 80%
Nutritional Counseling (When medically necessary) $20 per visit $35 per visit Plan covers 80%
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Allergy Injections Covered in full after deductible Plan covers 80%
Speech Therapy (no visit limit); Short-term Physical Therapy (30 visits per plan year); Short-term Occupational Therapy (30 visits per plan year)
Covered in full after deductible
Plan covers 80%
Spinal Manipulation (12 visits per plan year) Covered in full after deductible Plan covers 80%
Diagnostic Procedures Covered in full after deductible Plan covers 80%
Diagnostic Imaging - General Imaging
(such as X-rays and ultrasounds) Covered in full after deductible Plan covers 80%
Diagnostic Imaging - High-Tech Imaging
(MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology) Covered in full after deductible Plan covers 80%
Diagnostic Lab Tests Covered in full after deductible Plan covers 80%
Day Surgery Covered in full after deductible Plan covers 80%
Inpatient Hospital Care
after deductible)
All Hospital Services (Acute Care) and Maternity Care Covered in full after deductible Plan covers 80%
Skilled Nursing in Skilled Nursing Facility
(up to 100 days per plan year)
Covered in full after deductible Plan covers 80%
Emergency Care PCP Specialist
In Provider's Office $20 per visit $35 per visit
In Emergency Room $100 per visit
Mental Health
deductible)
Outpatient Care $20 per visit Plan covers 80%
Inpatient Care Covered in full after deductible Plan covers 80%
Substance Abuseut-of-Network
(after deductible)
Outpatient Care (Alcohol and drug treatment, detoxification) $20 per visit Plan covers 80%

Inpatient Care Covered in full after deductible Plan covers 80%

Other Health Services-of-Network

(after deductible)

Durable Medical Equipment Covered in full Plan covers 80%

Ambulance Service Covered in full after deductible Plan covers 80%

Hospice Care Covered in full after deductible Plan covers 80%

Home Health Care Covered in full after deductible Plan covers 80%

We want to help you and your family incorporate activity into your daily lives. That's why your Tufts Health Plan membership includes a **$150 rebate** per subscriber household toward your fees for a qualified health and fitness club.

There are some services that the plan does not cover. These include, but are not limited to: A service or supply not described as a covered service in your Tufts Health Plan member benefit document • Exams required by a third party, such as your employer, an insurance company, school, or court • Cosmetic surgery or any other cosmetic procedure, except certain reconstructive procedures described in your Tufts Health Plan member benefit document • Experimental or investigational drugs, services, and procedures • Eyeglasses or contact lenses, except as described in your Tufts Health Plan member benefit document • Blood, blood donor fees, blood storage fees, blood substitutes, blood banking, cord blood banking, or blood products, except as described in your Tufts Health Plan member benefit document • Drugs for use outside of a hospital, except as described in your Tufts Health Plan member benefit document • Personal comfort items • Custodial care • A service furnished to someone other than the member • Routine foot care, except as described in your Tufts Health Plan member benefit document • Charges incurred for stays in a covered facility beyond the discharge hour • Care for conditions that state or local law requires to be treated in a public facility • Medical or surgical procedures for sexual reassignment and reversal of voluntary sterilization • Foot orthotics, except therapeutic/molded shoes for an individual with severe diabetic foot disease • Assisted reproductive technology (e.g. IVF) procedures for non-Massachusetts residents • Spinal manipulation services for members age 12 and under • Except for Emergency care or urgent care while traveling, a service, supply or medication that is obtained outside of the 50 United States • Private duty nursing (block or nonintermittent nursing) • Hearing aids.

This is a summary only. Please refer to your plan's member benefit document for more detailed information. If there is a difference between the information in this benefit summary and your member benefit document, member benefit document is legally binding. If you have additional questions, please call a Member Specialist at 1-800-462-0224.

Offered by Tufts Insurance Company or Tufts Benefit Administrators, Inc., both Tufts Health Plan companies.

Massachusetts Requirement to Purchase Health Insurance: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector Web site (www.mahealthconnector.org). This health plan meets Minimum Creditable Coverage standards that are effective January 1, 2009 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards. This disclosure is for minimum creditable coverage standards that are effective January 1, 2009.

Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards. If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its Web site at www.mass.gov/doi.

Schedule of Benefits

The Harvard Pilgrim Tiered Copayment HMO

Services listed are covered when Medically Necessary and provided or arranged by Harvard Pilgrim Health Care providers. Please see your Benefit Handbook for details.

Member Cost Sharing Summary

Your benefits are being provided on a Plan Year basis. Your Plan Year begins on your Employer's Anniversary Date. Please see your Benefit Handbook for more details. If you do not know your Employer's Anniversary Date, please contact your Employer's benefits office or call the Member Services Department at 1-888-333-4742.

Deductible

A Deductible is a specific annual dollar amount that is payable by the Member before medical benefits subject to the Deductible are available under the Plan. Not all services under this Plan are subject to the Deductible. For services subject to the Deductible, you must satisfy your Deductible before Harvard Pilgrim provides coverage for these benefits. Deductible amounts are incurred as of the date of service.

Your Plan has a $250 per Member Deductible and a $500 per family Deductible per Plan Year.

Unless a family Deductible applies, each Member is responsible for the per Member Deductible for covered services each Plan Year. If a family Deductible applies, it is met when any combination of Members in a covered family incur expenses for services subject to the Deductible that total the annual family Deductible.

Your Deductible applies to all services covered under the Plan except the following:

- Examinations and consultations performed by physicians and podiatrists
- The Preventive Services as listed in the "Physician Services" Section of this Schedule of Benefits
- Prenatal and postpartum care in a physician's office
- Routine nursery charges for newborn care
- Outpatient mental health care services
- Pediatric preventive dental care
- Blood glucose monitors, insulin pumps and infusion devices
- Early intervention services

Please note that (1) treatments and procedures by physicians and podiatrists and (2) psychological testing and neuropsychological assessments are subject to the Deductible.

Deductible and Other Cost Sharing

For certain services, both a Deductible and Copayment may apply. In such cases, you must completely satisfy the Deductible before the Plan pays benefits on services subject to the Deductible. Once you have satisfied the annual Deductible, you are still responsible for any applicable Copayments.

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Copayments

A Copayment applies to all services except where specifically noted in the table below.

A Copayment is a dollar amount that is payable by the Member for certain covered services. The Copayment is due at the time services are rendered or when billed by the provider.

There are two types of office visit Copayments that apply to your Plan. A lower Copayment, known as "Copayment Level 1," applies to some outpatient services, including most primary care, obstetrical care, gynecological care, mental health care and substance abuse rehabilitation. Most outpatient specialty care requires payment of a higher Copayment, known as "Copayment Level 2." The Level 1 and Level 2 Copayments that apply to your Plan are listed below.

Copayment Level 1: Your Plan has a $20 Copayment per visit.

Copayment Level 2: Your Plan has a $35 Copayment per visit.

Copayment Level 1

Special Level 1 Services: Copayment Level 1 applies to the following outpatient services:

- Voluntary termination of pregnancy

- Voluntary sterilization
- Mental health care (including the treatment of substance abuse disorders)
- Physical therapy
- Occupational therapy
- Speech therapy
- Routine eye examinations
- Artificial insemination
- Advanced reproductive technologies

In addition to the Special Level 1 list, Copayment Level 1 applies to covered outpatient professional services, other than services received at a professional office operated by a hospital, from the following types of providers:

- All Primary Care Physicians. The term "Primary Care Physician" (PCP) includes the following specialties: Internal Medicine, Family Practitioner, General Practitioner and Pediatrician
- Obstetricians and Gynecologists
- Certified Nurse Midwives
- Nurse Practitioners who bill independently

Copayment Level 2

Copayment Level 2 applies to the following outpatient professional services:

- Any covered services or provider not listed under Copayment Level 1
- Any service provided in a hospital operated doctor's office, except the Special Level 1 Services listed above.

If a provider is categorized as both a Copayment Level 1 provider and a Copayment Level 2 provider, Copayment Level 1 applies. For example, if a provider is both a PCP and a cardiologist, you will be responsible for Copayment Level 1.

Your identification card indicates the Copayment amounts for the Plan's most frequently used services. This *Schedule of Benefits* provides further detail on all Copayment requirements.

The Harvard Pilgrim Tiered Copayment HMO 3

Please note: In very limited cases the Copayment may exceed the contract rate payable by the Plan for a service. If the Copayment is greater than the contract rate, you are responsible for the full Copayment, and the provider keeps the entire Copayment.

Out-of-Pocket Maximums

Your plan has an Out-of-Pocket Maximum of $1,000 per Member and $2,500 per covered family per Plan Year. This is the total amount in Copayments and Deductible you (or your covered family) are required to pay each Plan Year for services covered by the Plan, not including riders providing benefits for prescription drugs or vision hardware. The Plan will notify you when you have reached your Out-of-Pocket Maximum. If you feel you have reached the Out-of-Pocket Maximum but have not been notified, please contact the Plan.

The Deductible applies to all services except where specifically noted below.

The Harvard Pilgrim Tiered Copayment HMO 4

Service

Inpatient Acute Hospital Services

All covered services, including the following:

- Coronary care

Covered in full after the Deductible has been met.

- Hospital services
- Intensive care
- Semi-private room and board
- Physicians' and surgeons' services including consultations

Day Surgery Covered in full after the Deductible has been met.

Hospital Outpatient Department Services

- All covered services, except emergency room care Covered in full after the Deductible has been met.

No cost sharing applies to certain preventive care services and tests. See "Physician Services" and "Preventive Services" section below.

Diagnostic Procedures (including all technical and professional charges)

All covered services, including the following:
- Laboratory tests, Nuclear Magnetic Resonance Imaging, Ultrasounds* and x-rays (except for the x-rays provided as part of a pediatric preventive dental visit)

Covered in full after the Deductible has been met.
- Endoscopic procedures
- Blood and urine tests*
- Diagnostic procedures*

*No cost sharing applies to fetal ultrasounds and any services and tests listed in the "Preventive Services" section below.

Emergency Services

- You are always covered for care in a Medical Emergency. A referral from your PCP is not needed. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. If you are hospitalized, you must call your PCP within 48 hours or as soon as you can. Please note that this requirement is met if your attending physician has already given notice to your PCP.

$100 Copayment per visit. This Copayment is waived if admitted directly to the hospital from the emergency room. See "Physician Services" for coverage of emergency services by a physician in any other location.

The Harvard Pilgrim Tiered Copayment HMO 5

Physician Services (including covered services by podiatrists)

Examinations and Consultations

- Examinations for illness or injuries

Copayment Level 1: $20 Copayment per visit. The Deductible does not apply to these services.

Copayment Level 2: $35 Copayment per visit. The Deductible does not apply to these services.
- Routine eye examinations, including glaucoma screenings
- Routine hearing examinations and tests
- Health education, including nutritional counseling and diabetes education and training
- Family planning consultations
- Medication management, including psychopharmacological services
- Consultation with specialists
- Consultations concerning contraception and hormone replacement therapy
- Preventive care, including routine physical, gynecological, well child, school, camp, sports and premarital examinations

Covered in full. The Deductible does not apply to these services.

Treatments and Procedures (including all diagnostic procedures)

All covered services including the following:
- Administration of injections

Covered in full after the Deductible has been met.
- Allergy treatments
- Diagnostic procedures
- Casting, suturing and the application of dressings
- Chemotherapy
- Radiation therapy
- Infertility treatment and procedures
- Pregnancy testing
- Voluntary sterilization, including tubal ligation
- Voluntary termination of pregnancy
- Insertion, removal and fitting of birth control devices
- Genetic counseling
- Surgical procedures
- Non-routine foot care
- Foot care for members with severe diabetic foot disease
- Administration of allergy injections
- Medical treatment of temporomandibular joint dysfunction (TMD)

The Harvard Pilgrim Tiered Copayment HMO 6

Preventive Services (including all technical and professional charges)

The following preventive services and tests as defined by federal law:
- Abdominal aortic aneurysm screening (for males 65-75 one time only, if ever smoked)

Covered in full. The Deductible does not apply to these services.
- Alcohol misuse screening and counseling (primary care visits only)
- Aspirin for the prevention of heart disease (primary care counseling only)
- Autism screening (for children at 18 and 24 months of age, primary care visits only)
- Behavioral assessments (children of all ages; developmental surveillance, in primary care settings)
- Blood pressure screening (adults, without known hypertension)
- Breast cancer chemoprevention (counseling only for women at high risk for breast cancer and low risk for adverse effects of chemoprevention)
- Breast cancer screening, including mammograms and counseling for genetic susceptibility screening
- Cervical cancer screening, including pap smears
- Cholesterol screening (for adults only)
- Colorectal cancer screening, including colonoscopy, sigmoidoscopy and fecal occult blood test
- Dental caries prevention - oral fluoride (for children to age 5 only) (Note: Coverage for fluoride is only provided if your Plan includes outpatient pharmacy coverage.)
- Depression screening (adults, children ages 12-18, primary care visits only)
- Diabetes screenings
- Diet behavioral counseling (included as part of annual visit and intensive counseling by primary care clinicians or by nutritionists and dieticians)
- Dyslipidemia screening (for children at high risk for higher lipid levels)
- Folic acid supplements (women planning or capable of pregnancy only) (Note: coverage for folic acid is only provided if your Plan includes outpatient pharmacy coverage.)
- Hemoglobin A1c
- Hepatitis B testing
- HIV screening
- Immunizations, including flu shots (for children and adults as appropriate)
- Iron deficiency prevention (primary care counseling for children age 6 to 12 months only)

- Lead screening (children at risk)
- Microalbuminuria test
- Obesity screening (adults and children screening only, in primary care settings)
- Osteoporosis screening (screening to begin at age 60 for women at increased risk)
- Ovarian cancer susceptibility screening
- Sexually transmitted diseases (STDs) – screenings and counseling
- Tobacco use counseling (primary care visits only)
- Total cholesterol tests
- Tuberculosis skin testing
- Vision screening (children to age 5 only)

The Harvard Pilgrim Tiered Copayment HMO 7

Preventive Services (including all technical and professional charges) (Continued)

Under federal law the list of preventive care services covered under this benefit may change periodically based on the recommendations of the following agencies:

a. Grade "A" and "B" recommendations of the United States Preventive Services Task Force;

b. With respect to immunizations, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

c. With respect to services for woman, infants, children and adolescents, the Health Resources and Services Administration.

Information on the recommendations of these agencies may be found on the web site of the US Department of Health and Human Services at:

http://www.healthcare.gov/center/regulations/prevention/recommendations.html

Harvard Pilgrim will add or delete services from this benefit for preventive care in accordance with changes in the recommendations of the agencies listed above. You can find a list of the current recommendations for preventive care on Harvard Pilgrim's web site at www.harvardpilgrim.org.

Coverage is also provided for the following preventive services and tests:

- Hepatitis C testing

Covered in full. The Deductible does not apply to these services.

- Prostate-specific antigen (PSA) screening
- Fetal ultrasounds
- Routine hemoglobin
- Routine urinalysis
- Alpha-Fetoprotein (AFP) and Group B streptococcus (GBS) test
- All lab handling and venipuncture charges

Maternity Services

- Prenatal and postpartum care, including counseling about alcohol and tobacco use, services to promote breastfeeding, routine urinalysis and screenings for the following: asymptomatic bacteriuria; hepatitis B infection; HIV and screenings for STDs (chlamydia, gonorrhea and syphilis); iron deficiency anemia; and Rh (D) incompatibility.

Covered in full.

- All hospital services for mother, including inpatient physician services Covered in full after the Deductible has been met.
- Routine nursery charges for newborn care, including prophylactic medication to prevent gonorrhea and screenings for the following: hearing loss; congenital hypothyroidism; phenylketonuria (PKU); and sickle cell disease.

Covered in full.

The Harvard Pilgrim Tiered Copayment HMO 8

Mental Health Care (Including the Treatment of Substance Abuse Disorders)

Inpatient Services

- Mental health care services Covered in full after the Deductible has been met.

Intermediate Care Services

 Acute residential treatment (including detoxification), crisis stabilization and inhome family stabilization Covered in full after the Deductible has been met.
 Intensive outpatient programs, partial hospitalization and day treatment programs

Outpatient Services

 Mental health care services
Group therapy $10 Copayment per visit.
Individual therapy $20 Copayment per visit. The Deductible does not apply to these services.
 Detoxification $20 Copayment per visit. The Deductible does not apply to these services.
 Medication management $20 Copayment per visit. The Deductible does not apply to these services.
 Psychological testing and neuropsychological assessment Covered in full after the Deductible has been met.

Home Health Care Services

 Home care services Covered in full after the
 Intermittent skilled nursing care Deductible has been met.

No cost sharing or benefit limit applies to durable medical equipment, physical therapy or occupational therapy received as part of authorized home health care.

Dental Services

 Preventive care for children through age 12. Two visits per Member per Plan Year, including examination, cleaning, x-rays and fluoride treatment. $20 Copayment per visit. The Deductible does not apply to these services.
 Extraction of unerupted teeth impacted in bone Covered in full after the Deductible has been met.
 Initial emergency treatment (within 72 hours of injury) Covered in full after the Deductible has been met. For emergency room care, see your "Emergency Services" Copayment below. For care in any other location, covered in full after the Deductible has been met.

The Harvard Pilgrim Tiered Copayment HMO 9

Skilled Nursing Facility Care Services

 Covered up to 100 days per Plan Year Covered in full after the Deductible has been met.

Inpatient Rehabilitation Services

 Covered up to 100 days per Plan Year Covered in full after the Deductible has been met.

Diabetes Equipment and Supplies

 Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids Covered in full after the Deductible has been met.
 Blood glucose monitors, insulin pumps and supplies and infusion devices Covered in full. The Deductible does not apply to these services.

 Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips
Subject to the applicable prescription drug Copayment listed on your ID card.

Durable Medical Equipment including Prosthetics

Coverage includes, but is not limited to:
 Durable medical equipment
Covered in full after the Deductible has been met.
 Prosthetic devices (including artificial arms and legs)
 Ostomy supplies
 Breast prostheses, including replacements and mastectomy bras
 Oxygen and respiratory equipment
 Wigs - up to a limit of $350 per Plan Year when needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury

Hypodermic Syringes and Needles

 Hypodermic syringes and needles to the extent Medically Necessary, as required by Massachusetts law
Subject to the applicable prescription drug Copayment listed on your ID card.

The Harvard Pilgrim Tiered Copayment HMO 10

Other Health Services

 Cardiac rehabilitation
Covered in full after the Deductible has been met.
 Dialysis
 Physical and occupational therapies - up to 90 consecutive days per condition per Plan Year
 Speech-language and hearing services, including therapy
 Hospice services
 Ambulance services
 Low protein foods ($5,000 per Member per Plan Year)
 State mandated formulas
 House calls
 Early intervention services up to a maximum of $5,200 per Member per Plan Year and a lifetime maximum of $15,600 Covered in full.
 Vision hardware for special conditions Covered in full after the Deductible has been met., up to the applicable benefit limits as described in the Benefit Handbook.

The Harvard Pilgrim Tiered Copayment HMO 11

Special Enrollment Rights

For Subscribers enrolled through an Employer Group:
If an employee declines enrollment for the employee and his or her Dependents (including his or her spouse) because of other health insurance coverage, the employee may be able to enroll himself or herself, along with his or her Dependents in this Plan if the employee or his or her Dependents lose eligibility for that other coverage (or if the employer stops contributing toward the employee's or Dependents' other coverage). However, enrollment must be requested within 30 days after other coverage ends (or after the employer stops contributing toward the employee's or Dependents' other coverage). In addition, if an employee has a new Dependent as a result of

marriage, birth, adoption or placement for adoption, the employee may be able to enroll himself or herself and his or her Dependents. However, enrollment must be requested within 30 days after the marriage, birth, adoption or placement for adoption.
Special enrollment rights may also apply to persons who lose coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for state premium assistance under Medicaid or CHIP. An employee or Dependent who loses coverage under Medicaid or CHIP as a result of the loss of Medicaid or CHIP eligibility may be able to enroll in this Plan, if enrollment is requested within 60 days after Medicaid or CHIP coverage ends. An employee or Dependent who becomes eligible for group health plan premium assistance under Medicaid or CHIP may be able to enroll in this Plan if enrollment is requested within 60 days after the employee or Dependent is determined to be eligible for such premium assistance.

Membership Requirements

There are a few important requirements that you must meet in order to be covered by the Plan. (Please see your *Benefit Handbook* for a complete description).

- Members must live in the HPHC's Enrollment area for at least nine months of the year. An exception is made for full-time student dependents and dependents enrolled under a Qualified Medical Child Support Order.
- All your medical and health care needs must be provided or arranged by your Primary Care Physician (PCP), except in a Medical Emergency, when you are temporarily outside the HPHC Service Area or when you need one of the special services, which do not require a referral. The HPHC Service Area is the state in which you live.

Exclusions

The Harvard Pilgrim Tiered Copayment HMO 12

- Services not approved, arranged or provided by your PCP except: (1) in a Medical Emergency; (2) when you are outside of the Service Area; or (3) the special services that do not require a referral listed in your Benefit Handbook
- Cosmetic procedures, except as described in your Benefit Handbook
- Commercial diet plans or weight loss programs and any services in connection with such plans or programs
- Transsexual surgery, including related drugs or procedures
- Drugs, devices, treatments or procedures which are Experimental or Unproven
- Refractive eye surgery, including laser surgery and orthokeratology, for correction of myopia, hyperopia and astigmatism
- Transportation other than by ambulance
- Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities
- Costs for services covered by workers' compensation, third party liability, other insurance coverage or an employer under state or federal law
- Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy
- Routine foot care, biofeedback, pain management programs, massage therapy, including myotherapy, and sports medicine clinics

- Any treatment with crystals
- Blood and blood products
- Educational services (including problems of school performance) or testing for developmental, educational or behavioral problems except services covered under Early Intervention
- Mental health care (including the treatment of substance abuse disorders) that are (1) provided to Members who are confined or committed to a jail, house of correction, prison or custodial facility of the Department of Youth Services or (2) provided by the Department of Mental Health
- Sensory integrative praxis tests
- Physical examinations for insurance, licensing or employment
- Vocational rehabilitation or vocational evaluations on job adaptability, job placement or therapy to restore function for a specific occupation
- Rest or custodial care
- Personal comfort or convenience items (including telephone and television charges), exercise equipment, wigs (except as required by state law and specifically covered in this Schedule of Benefits), derotation knee braces and repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage or theft
- Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services
- Reversal of voluntary sterilization (including procedures necessary for conception as a result of voluntary sterilization)
- Any form of surrogacy
- Infertility treatment for Members who are not medically infertile
- Routine maternity (prenatal and postpartum) care when you are traveling outside the Service Area
- Delivery outside the Service Area after the 37th week of pregnancy or after you have been told that you are at risk for early delivery
- Planned home births
- Devices or special equipment needed for sports or occupational purposes
- Care outside the scope of standard chiropractic practice, including, but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice or treatment of infections and diagnostic testing for chiropractic care other than an initial x-ray
- Services for which no charge would be made in the absence of insurance

 Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs and hospital or other facility charges that are related to any care that is not a covered service under this Handbook
 Services for non-Members
 Services after termination of membership
 Services or supplies given to you by: (1) anyone related to you by blood, marriage or adoption or (2) anyone who ordinarily lives with you

Exclusions

The Harvard Pilgrim Tiered Copayment HMO 13

 Charges for missed appointments
 Services that are not Medically Necessary
 Services for which no coverage is provided in the *Benefit Handbook*, *Schedule of Benefits* or *Prescription Drug Brochure* (if your Plan includes prescription drug coverage)
 Any home adaptations, including, but not limited to, home improvements and home adaptation equipment
 All charges over the semi-private room rate, except when a private room is Medically Necessary
 Hospital charges after the date of discharge
 Follow-up care to an emergency room visit unless provided or arranged by your PCP
 Services for a newborn who has not been enrolled as a Member, other than nursery charges for routine services provided to a healthy newborn
 If your Plan does not include coverage for outpatient prescription drugs, there is no coverage for birth control drugs, implants, injections and devices
 Acupuncture, aromatherapy and alternative medicine
 Dentures
 Dental services, except the specific dental services listed in your Benefit Handbook and this Schedule of Benefits. Restorative, periodontal, orthodontic, endodontic, prosthodontic and dental services for temporomandibular joint dysfunction (TMD) are not covered. Removal of impacted teeth to prepare for or support orthodontic, prosthodontic or periodontal procedures and dental fillings, crowns, gum care, including gum surgery, braces, root canals, bridges and bonding.
 Eyeglasses, contact lenses and fittings, except as listed in your Benefit Handbook and this Schedule of Benefits
 Hearing aids
 Foot orthotics, except for the treatment of severe diabetic foot disease

- Methadone maintenance
- Private duty nursing
- If a service is listed as requiring that it be provided at a Center of Excellence, no coverage will be provided under your *Benefit Handbook* and this *Schedule of Benefits* if that service is received from a provider that has not been designated as a Center of Excellence by HPHC.
- Health resorts, recreational programs, camps, wilderness programs, outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs.
- Services for any condition with only a "V Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder.
- Chiropractic services, including osteopathic manipulation.

Attachment F- Page 1

12/18 Contract

Price Proposal

Proposer: _____ **Addendum No. _____**

Tufts EPO, POS and Harvard Pilgrim EPO
For City of Newton
Specific Stop-Loss:
7/01/2012 to 6/30/2013

DEDUCTIBLE	CONTRACT TYPE	ENROLLMENT	MONTHLY RATE	EST ANNUAL COST
$250,000	Individual	1386		
	Family	1583		
	Total	2969		
$225,000	Individual	1386		
	Family	1583		
	Total	2969		
$200,000	Individual	1386		
	Family	1583		
	Total	2969		

ATTACHMENT G

Contractual Requirements

The reinsurance contract awarded and signed by the City of Newton will comply with all of the following requirements:

1. Reinsurance will apply to the plans named in this Request for Quotations, which are currently administered by Tufts Total Health Plan and Harvard Pilgrim Health Care.

2. For the above named health plans, reinsurer will reimburse City of Newton for claims exceeding the specific deductible per claimant based on the policy terms selected by the City of Newton.

3. Reinsurer will cover subscriber plus dependents including covered retirees and COBRA beneficiaries.

4. Reinsurer will cover all benefits of City of Newton's health plans, including but not limited to medical, prescription drugs, mental and nervous treatment, substance abuse treatment and current and future government mandated benefits. *(Note 1: City of Newton plans are not ERISA plans, and City of Newton adopts state and federal government mandated benefits.)*

5. Reinsurer will cover mental health/nervous claims at the same level as medical/surgical claims.

6. Reinsurer will reimburse City of Newton based on the contractual basis of payment applied by the claims administrator/health plan even if basis of payment exceeds charges. Reinsurer will not pay the lesser of charges or actual contractual basis of payment.

7. Reinsurer will not exclude from coverage covered employees, dependents of employees, retirees, and dependents of retirees with pre-existing conditions.

8. Reinsurer will not exclude from coverage covered members who are not actively at work at the time the policy goes into effect or during the term of the policy.

9. Reinsurer will not exclude from coverage dependents who are hospitalized or otherwise institutionalized at the time the reinsurance policy goes into effect.

10. Reinsurer will not exclude from coverage "Late Entrants" into the City of Newton health plans, such as new hires and those who have lost other coverage as through a spouse.

11. Massachusetts municipal employees hired prior to April 1986 did not pay into Medicare, and, therefore, many not have Medicare eligibility. Therefore, the reinsurer selected by the City of Newton agrees to reimburse for excess claims for retirees who are 65 and older and not eligible for Medicare.

12. Reinsurer will cover all City of Newton plan members at the selected specific deductible and with a either a maximum benefit payable of not less than $2 million benefit, depending upon the option selected by the City of Newton. No special underwriting for high cost claimants, i.e. no "lasering" will be permitted.

13. Reinsurer will designate surcharges imposed by the Mass. Uncompensated Care law of 1997 paid on hospital charges and outpatient facility charges including day surgery centers as eligible claims expenses for the City of Newton.

14. Reinsurer will designate surcharges paid to the Pool Administrator of the State of New York under the New York Health Care Reform Act of 1996 as eligible claims expense for the City of Newton.

15. Reinsurer will reimburse for claims that exceed the specific deductible according to the policy when filed late because the health plan/claims administer did not report the claim to the client in a timely manner, provided the client reports the claim to the broker or carrier within five business days of receipt of the information from the health plan.

STATEMENT of COMPLIANCE with CONTRACTUAL REQUIREMENTS in ATTACHMENT G of CITY OF NEWTON REQUEST for QUOTATIONS for REINSURANCE

The undersigned certifies that if the reinsurance carrier, _____,
Name of Carrier
is awarded the reinsurance contract sought through this Request for Proposal process, carrier will enter into a contract with the City of Newton that complies with all of the contractual requirements specified in **Attachment G** of the City of Newton's Request for Quotations issued May, 2012 and proposals due June 1, 2012. There will be no exceptions. If the reinsurance carrier's standard contract does not meet all of the requirements specified in Attachment G, carrier will prepare, sign, and submit amendments to the contract in a timely manner to render the contract in compliance.

The undersigned also acknowledges that if reinsurance carrier does not comply with Contractual Requirements, the City of Newton will exercise its right to withdraw the contract award.

_____ _____
(Signature of individual authorized to bind the reinsurance carrier) (Date)

COMMONWEALTH OF MASSACHUSETTS

_____
(County)

Then appeared before me the above-named _____

and having been duly sworn stated that the foregoing statements were true and correct.

_____

(Notary Public)

My commission expires:

_____
(Date)

Federal Identification Number:_____

ATTACHMENT - H

Rate History and Miscellaneous Information

Since July 1, 1994, the City of Newton has had the same plans for its employees and its retirees.

The two Tufts plans have been self-insured since July 1, 1994. They are:
- Tufts EPO plan
- Tufts POS/OOA/ Plan

The Tufts PPO Plan and EPO Advantage plans were added 8/1/11.

Harvard Pilgrim Advantage plan was added 8/1/11.

The Harvard Pilgrim HMO has also been in place since July 1, 1994. On July 1, 2000 the City chose to self-insure this plan.

The monthly rates for these plans for the last three years are as follows:

July 1, 2009:	Individual	Family
Tufts EPO	$556.52	$1,506.20
Tufts POS/OOA	$819.86	$1,987.05
Harvard Pilgrim	$572.31	$1,554.36

July 1, 2010:	Individual	Family
Tufts EPO	$556.52	$1,506.20
Tufts POS/OOA	$819.86	$1,987.05
Harvard Pilgrim	$612.37	$1,663.17

July 1, 2011, 2012	Individual	Family
Tufts EPO	628.87	1702.01
Tufts EPO Advantage	570.35	1565.62
Tufts POS	926.55	2245.37
Tufts PPO Advantage	880.23	2133.10
Harvard Pilgrim	655.16	1779.41
Harvard Pilgrim Advantage	560.55	1592.78